

CHAPTER 6

Combat Stress and Its Effects: Combat's Bloodless Casualties

It is hard to equate our civilian experiences with fear to the combat situation. Here danger is imminent and ever present. It is a constant companion every hour of the day, every day of the week. The enormity of this fear is hard to portray and without such an experience, hard to imagine; later, dispersed with prolonged periods facing this fear, are long periods of sheer boredom and frustration—always with the knowledge that the enemy has to be faced again. Fear and its effects are cumulative . . . [t]o each experience is added another. . . . [I]f there is no chance at relief or no additional factors to sustain [the soldier], the potentiality for combat exhaustion exists. [Or alternatively] his judgment is not as good; his alertness may suffer, and his willingness to take chances may disappear. He and his men may become physical casualties long before they become psychological casualties.¹ (pp3–4)

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This is a photograph of a combat fatality taken at the 15th Medical Battalion Clearing Station/1st Cavalry Division at Phouc Vinh in 1970. Although the combat intensity in Vietnam was highest during the early and middle years of the war, apprehensions about becoming a casualty remained the preeminent psychological stress factor for Army troops assigned throughout the war. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).



Elements of the history of Army psychiatry that addressed the importance of the prevention and timely treatment of soldiers affected by combat stress were reviewed in Chapter 2. In particular it was demonstrated that in the high intensity wars that preceded Vietnam, rates for soldier attrition and disability from the effects of combat stress could rise to levels sufficient to threaten the outcome of military engagements.

For America and its allies, the Vietnam War also started as a high-intensity, main force war. However, shortly after it began the enemy concluded that the allied forces could not be defeated in large-scale attacks, and they resorted mostly to terrorist/guerrilla tactics. What followed was a protracted, bloody, politically charged, low-intensity war that came

to be bitterly opposed by the American public and the international community. In general, and especially during heightened combat activity, treatment of acute combat-generated psychiatric casualties, including what some referred to as classic combat exhaustion, was required of medical and mental health personnel at all levels of care. (In this volume, the term *combat exhaustion* is used synonymously with the terms *combat fatigue*, *combat reaction*, *combat stress reaction* [CSR], and, in some instances, *combat breakdown*.)

Compared with other psychiatric conditions, however, such combat stress reactions, at least in the forms seen in earlier wars, appeared to be well below expected levels. This does not mean that they had no clinical impact, just that their numbers did not constitute a threat to military effectiveness and success. As a result, psychiatric attention was redirected to the burgeoning behavior and disciplinary problems, especially racial tensions and incidents, challenges to military authority, drug abuse, and the number of soldiers diagnosed with character and behavior disorders (ie, personality disorders²)—problems not limited to combat troops and thus not regarded as closely tied to participation in combat. However, these behavior problems, as well as ones that were more obviously combat-specific (ie, combat refusals and excessive combat aggression), along with psychosomatic conditions and low-grade psychiatric symptoms (anxiety, depression, and “short-timer’s syndrome”), continued to arise in the theater, representing “hidden casualties”³—conditions that would not have been considered among the more traditional measures of the psychiatric costs of fighting in Vietnam. In fact, the greatest impact may have been among veterans. Many have argued that the proportion of Vietnam veterans with debilitating psychological and social problems greatly exceeded those from earlier American wars, but the connection between combat stress symptoms in the theater and symptoms arising after the war, including what would come to be called posttraumatic stress disorder (PTSD), has remained inconclusive.⁴ (Further discussion of PTSD and the postwar adjustment of Vietnam veterans can be found later in this chapter as well as in Chapters 2, 11, and 12.)

This chapter begins with a review of the phenomenological features and etiologic assumptions associated with combat exhaustion (currently included in combat and operational stress reaction [COSR]). It also utilizes the available psychiatric literature pertaining

to the war to estimate the incidence of combat exhaustion cases in Vietnam. In addition, it explores some of the unique features of the combat ecology in Vietnam, provides case examples, and presents selected findings from the 1982 Walter Reed Army Institute of Research (WRAIR) Psychiatrists’ Survey in an effort to further define the nature of combat stress there and its various symptomatic consequences.

The material presented in this chapter extends the review of the Army’s forward treatment doctrine for combat stress casualties begun in Chapter 2. Management and treatment of combat reactions in Vietnam are discussed in Chapter 7. Finally, psychiatric and behavior problems in Vietnam that were not evidently associated with combat will be addressed in Chapter 8 as deployment stress reactions (currently called combat misconduct stress behavior). However, it should be noted that in many instances this distinction could be a misleading because the war was mostly a counterinsurgency/guerrilla war with no front lines and no deep, well-defended rear. Many psychiatric and behavior problems may have etiologically overlapped with overt combat reactions and belong at the other end of the spectrum of psychiatric and behavior disorders generated by the unique collection of combat-related stressors found throughout Vietnam.

BACKGROUND

The Classic Combat (Stress) Reaction: Psychosocial Regression Under Fire and the Loss of Combat Effectiveness

As indicated in Chapter 2, throughout the 20th century there was growing interest by military psychiatrists and other behavioral scientists regarding the physical and psychological limits of troops under fire and the prevention of soldier breakdown as well as its treatment.^{5–19} In the wars preceding Vietnam, combat reaction symptoms were noted to be diffuse and variable and sometimes spread among soldiers by suggestion.¹ Early-stage combat reaction symptoms progressed from normal anticipatory fear and uneasiness to hyper-alertness, irritability, difficulty concentrating, insomnia, somatic disturbances, and preoccupations with death and disability. Severity often increased if there was no relief or intervention, and the disorder advanced to a stage of gross disturbances in mood, thinking, and behavior²⁰ (Table 6-1).

TABLE 6-1. Combat Reaction Stages

	APPREHENSION “Normal Fear”	INCIPIENT Combat Reaction	PARTIAL Combat Reaction	COMPLETE Combat Reaction
Social and Behavioral	Appropriate Combat effective Close with comrades Shares fears with comrades	Add: Irritability	Reclusive Morose Overdependent and avoids responsibility Reduced initiative Impulsive Decreased interest in: combat, food, letters, etc. Unit members alarmed	Unstable Erratic Reckless or overcautious Savage irritability Unreasonable and defiant Sobbing Screaming Passive and helpless
Emotional and Cognitive	Increased vigilance Worries: death/mutilation incapacitating fear, losing caste with group through fear	Add: Startle reaction	Mild disorientation Reduced judgment Psychomotor retardation Affect blunting Depressed Ruminating regarding: survival, combat failure, excess combat aggression	Confused Disorganized Amnesic
Somatic	Tense Autonomic arousal (gastrointestinal disorders, etc.) Disturbed sleep (including sleepwalking) Psychosomatic complaints	Add: Major insomnia	Severe diarrhea and vomiting Somatic preoccupation	Stammering and incoherent Tremulous and uncoordinated Mute and staring Conversation symptoms: deaf, blind, paralyzed, convulsive

Drawn from observations made in the closing phases of World War II by a panel of distinguished civilian psychiatrists who visited the European theater. Data source: Bartemeier LH, Kubie LS, Menninger KA, Romano J, Whitehorn JC. Combat exhaustion. *J Nerv Ment Dis.* 1946;104:358–389.

Presenting symptoms for combat reactions were also influenced by the soldier’s specific combat circumstances, that is, the “ecology” of the battlefield,²¹ as well as the military’s medical evacuation requirements.^{7,22} They were also shaped by which symptom patterns the soldier’s reference group (combat buddies) found acceptable.²³ In this regard, his condition must appear to reflect incapacitation, as opposed to unwillingness, to continue to fight so that he isn’t judged to have succumbed to weakness or cowardice or to have manipulated an exit from the battlefield. Finally, obviously avoidant behaviors such as combat refusal, malingering, self-inflicted wounds, and desertion, as well as less direct ones such as alcohol and drug misuse; neglect of healthcare, weapons, or equipment; indiscipline; combat atrocities; and behaviors associated with “short-timer’s syndrome” were also thought to be associated with combat stress or the threat of it.

Diagnosis of the Combat Reaction

With regard to combat reaction cases, the fully affected soldier (“Complete combat reaction” in Table 6-1) is presumed to have undergone a profound psychological regression—a mental and social decompensation—as a consequence of having had his psychological endurance, as well as his combat motivation^{24,25} and adaptation, overwhelmed by the rigors, dangers, losses, or horrors of the combat situation. In other words, he has undergone psychological traumatization (for an example, see Chapter 2, Case 2-1, SP4 Delta). However, among soldiers who had little prior history of psychiatric problems or personality deficits, combat reactions have appeared to be transitory or reversible, especially when the soldier is managed with a vigorous but simple crisis-oriented regimen aimed at quickly restoring him to combat duty function—the military forward treatment

EXHIBIT 6-1. Phenomenological Elements in Diagnosing “Classic” Combat Reaction (Combat Exhaustion)

Five observable criteria for the diagnosis of classic combat reaction:

1. Stimulus: the affected soldier must have sustained *exceptionally stressful combat*, with the continued threat of danger as the essential element (and which is consistent with his interpretation of the threat).
2. Predisposition: distinctive by its relative absence; there is presumed *universal susceptibility* among soldiers, although individual vulnerability and coping capacities play a role in forms of presentation and severity.
3. Clinical course: there is *rapid deterioration* of the affected soldier’s combat adaptation and effectiveness in the face of his personal ordeal.
4. Presentation: the affected soldier evidences symptoms of a *disabling regression* of psychological and social functions.
5. Prognosis: the affected soldier typically has a *reversible course*, especially if he gets relief from the stress or receives timely, progressive, military-centered treatment.

SOURCES:

1. US Department of Defense. *The Joint Armed Forces Nomenclature and Method of Recording Psychiatric Conditions*. Washington, DC: DoD; June 1949. Special Regulation 40-1025-2.
2. Glass AJ. Military psychiatry and changing systems of mental health care. *J Psychiat Res*. 1971;8:499–512.
3. Glass AJ. Lessons learned. In: Glass AJ, ed. *Neuropsychiatry in World War II*. Vol 2. *Overseas Theaters*. Washington, DC: Medical Department, United States Army; 1973: 989–1027.
4. Cooke ET. *Another Look at Combat Exhaustion*. Fort Sam Houston, Tex: Department of Neuropsychiatry, Medical Field Service School; distributed July 1967. Training Document GR 51-400-320, 055.

doctrine.^{5,7,13,14} From these observations military psychiatrists have considered that the combat reaction may be a version of what is called acute stress reaction,²⁶ or acute stress disorder (ASD),^{27,28} in civilian psychiatry.

The diagnostic criteria for the classic combat reaction are delineated in Exhibit 6-1; however, this construct may be oversimplified. For instance, with regard to stimulus and civilian patients with acute stress reactions, some psychoanalyst theorists have found it useful to distinguish between: (1) shock trauma²⁹ (or “catastrophic trauma”³⁰) in instances of psychic disorganization and immobility following overwhelming danger, which would coincide with the classic combat reaction; (2) strain trauma²⁹ to allude to long-lasting stress situations causing trauma from cumulative frustration and tension; and (3) partial trauma³⁰ to describe a series of emotionally disturbing events, which, although failing to reach the threshold of trauma, nevertheless distort various mental functions and adaptation. Perhaps in lieu of the term *classic combat reaction*, the term *uncomplicated combat reaction* would be preferable. As will be explained, this becomes even more practical considering the history of confusion in military terminology.

Pathogenesis of the Combat Reaction

Earlier wars led military psychiatrists to believe that if the intensity of the fighting was high enough and the

duration of exposure of a soldier was indeterminate, then “every man has his breaking point.”^{5,10,31–33} When it became evident that the average soldier’s resiliency could be exceeded by combat stress, attention shifted away from the question of “who” (implying precombat susceptibility), and more toward the “when” and the “how.” Earlier assumptions of faulty personality development²³ or cowardice gave way to the perspective that the combat reaction represented a normal reaction to an abnormal situation,²⁰ at least in its acute stage (ie, it is a matter of limits in capacity as opposed to courage). In other words, the soldier’s combat motivation had been compromised by situational and environmental factors that raised his fears to intolerable levels and activated his self-preserved instincts. However, whereas this model may have broad, utilitarian applicability, it does not provide for variability at the level of the individual soldier. The following offers a more complex pathodynamic explanation.

A Bio\Psycho\Social Etiologic Model for Combat Reactions

Over the years research and systematic observation have established an extensive list of pre- and pericombat factors that strengthened the soldier’s adaptation and resilience under fire and opposed the onset of combat reactions. Chief among them are indoctrination and

FIGURE 6-1. The bio\psycho\social etiological model and the combat stress reaction (CSR). The shaded figure represents an individual soldier. Vector arrows represent combat stress challenging that soldier at successive levels of mental organization.

Social Supports:

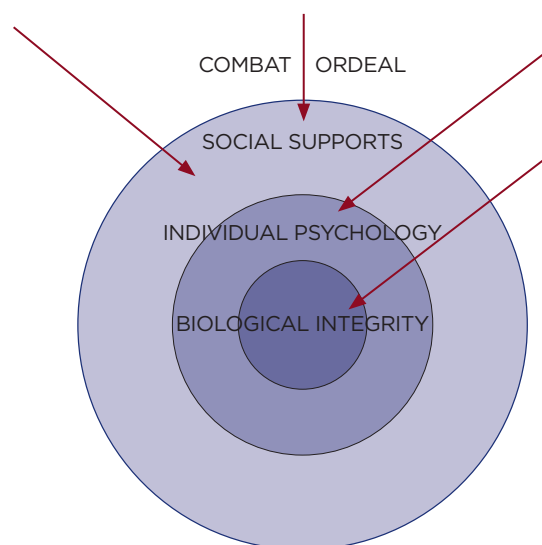
Failed social and environmental support
 —immediate, for example, within the small combat group (isolated, unprotected, poorly led, estranged, depleted, etc.)
 —remote, for example, that generated from home (uncared for, blamed, etc)

Individual Psychology and Motivation:

—low commitment to mission, to comrades (socially remote)
 —individual susceptibility leading to subjective distortion of the events (persecutory feelings, exaggerated fear, helplessness, rage, guilt, shame, panic, etc)

Biological Integrity:

Physical depletion (hot/cold, tired, hungry, wet, sleep deprived, over stimulated, exhausted, wounded, dehydrated) and associated organismic stress responses.



training; physical conditioning; stress inoculation³⁴; efficiency of communication; quantity and quality of supplies and weapons; reiteration of the military objective; support from home; and, especially, unit morale, cohesion, and leadership.^{17,20,32,35–42} (See Johnson's article, "Psychiatric Treatment in the Combat Situation," for a more complete list.²²) With respect to social supports, according to Albert J Glass, the preeminent combat psychiatrist in the last half of the 20th century, the inadequacy of sustaining relationships within the small combat group, or their disruption during combat, was the most important factor responsible for psychiatric breakdown in World War II and Korea.²³ Elsewhere Glass wrote:

Of special significance was the growing awareness that the stimuli of battle itself evoked a defensive process that sustained men in combat . . . the lonely, fearful battle environment forces individuals to join together for protection and emotional support . . . [W]hat began as mere instinctual huddling is crystallized into a powerful emotional bond of love and concern for comrades which deflects fear from the self and creates a compelling internal motivation for remaining with or rejoining the combat group.^{43(p728)}

Further explanation for this observation came from Jon A Shaw, an Army psychiatrist and psychoanalyst. According to Shaw, the intensification of combat group cohesion/morale stems from the soldiers' need to band with, and idealize, their combat buddies, and to maintain an illusion of their unit leader's omnipotence, so as to keep out of awareness their relative helplessness in battle and primitive concerns regarding biological vulnerability.⁴⁴

Questions regarding how much weight to give to individual predisposition have remained the more elusive variable in the combat reaction pathogenesis equation. Although it had been concluded that personality characteristics were of less importance in soldier breakdown in high-intensity combat,^{45,46} they appeared to be of increasing importance in cases arising in low-intensity combat⁴⁷ as well as influence recovery⁴⁸—observations that would have special pertinence for a counterinsurgency/guerrilla war like Vietnam.

The analysis of a specimen combat stress reaction case from World War II by Erik Erikson, the renowned psychologist and psychoanalyst, provides a useful theoretical model for intrapsychic (ie, mental or emotional) vulnerability and conflict within the affected soldier.⁴⁹ According to Erikson, apart from the traumatic potential of the combat experience itself,

to fully account for the soldier's psychological and functional deterioration under fire (Erikson would refer to it as a "crisis"), one needs to assume that there have been concurrent disruptions in all three primary centers of human experience—the somatic ("bio"), the psychological ("psycho"), and the social.

Refinement of Erikson's trilateral perspective in general is provided through George Engel's bio\psycho\ social model of psychiatric pathogenesis that argues for relating these levels hierarchically. According to Engel, appreciation of disturbances at the lower levels is necessary to comprehend, but not sufficient to explain, disturbances at higher levels.⁵⁰ Thus, this author [NMC] notes that in borrowing from Erikson and Engel, to fully conceptualize the pathogenesis of a case of combat stress reaction, one must not only consider the specific nature and extent of the soldier's combat ordeal (eg, its actual rigors, dangers, losses, or horrors) but also look for compounding disturbances generated from each of the levels of his mental organization, including those pertaining to his personality type and its limitations, especially his interpretation of his circumstances (ie, the personal "meaning" the events have for him alone) (see Figure 6-1).

That having been said, it should be underscored that, *in the field*, precombat susceptibility of the affected soldier can be difficult to assess because the forward treatment doctrine discourages approaches that might promote "patienthood." Based on experiences in Korea, Glass warned military psychiatrists not to focus on the soldier-patient's background features because this invites chronicity. ("Any therapy, including usual interview methods, that sought to uncover basic emotional conflicts or attempted to relate current behavior and symptoms with past personality patterns seemingly provided patients with logical reasons for their combat failure."^{43(p727)})

Below is a case report from the 935th Psychiatric Detachment that illustrates features consistent with the classic, or uncomplicated, combat reaction. Relevant discussion of this and other case reports will be presented in the text.

CASE 6-1: Disorganized, Regressed, Combat Stress Reaction After Unit Was Overrun

Identifying information: Corporal (CPL) Foxtrot was a 21-year-old rifleman who was flown directly to the 93rd Evacuation Hospital from an area of fighting by

a helicopter ambulance. No information accompanied him, he had no identifying tags on his uniform, and he was so completely covered with mud that a physical description of his features was not possible. He also was disorganized and incapable of cooperating with a formal evaluation.

History of present illness: CPL Foxtrot's symptoms developed when his platoon had been caught in an ambush and then overrun by the enemy. He was one of three who survived after being pinned down by enemy fire for 12 hours. Toward the end of that time he developed a crazed expression and had tried to run from his hiding place. He was pulled back to safety and remained there until the helicopter arrived and flew him to the hospital.

Past history: He had no history of similar symptoms or emotional disorder.

Examination: His hands had been tied behind him for the flight, and he had a wild, wide-eyed look as he cowered in a corner of the emergency room, glancing furtively to all sides, cringing and startling at the least noise. He was mute, although once he forced out a whispered "VC" ["Viet Cong"] and tried to mouth other words without success. He seemed terrified. Although people could approach him, he appeared oblivious to their presence. No manner of reassurance or direct order achieved either a verbal response or any other interaction from him. His hands were untied, after which he would hold an imaginary rifle in readiness whenever he heard a helicopter overhead or an unexpected noise.

Clinical course: The corpsmen led CPL Foxtrot to the psychiatric ward, took him to a shower, and offered him a meal; he ate very little. He began to move a little more freely but still offered no information. He was then given 100 mg. of Thorazine orally, and this dose was repeated hourly until he fell asleep. He was kept asleep in this manner for approximately 40 hours. After that he was allowed to waken, the medication was discontinued, and he was mobilized rapidly in the ward milieu. Although initially dazed and subdued, his response in the ward milieu was dramatic. This was aided by the presence of a friend from his platoon on an adjoining ward who helped by filling in parts of the story that the patient could not recall. Within 72 hours following his admission the patient was alert, oriented,

responsive, and active. Although still a little tense, he was ready to return to duty.

Discharge diagnosis: Combat exhaustion, moderately severe.

Disposition: On his third hospital day he was returned to duty with his unit and never seen again at the 935th.

Source: Clinical record narrative summary. A version of the case of CPL Foxtrot was published as Bloch HS. Army clinical psychiatry in the combat zone: 1967-1968. *Am J Psychiatry*. 1969;126(3):294.

Critical Distinctions Between Combat and Civilian Stress Casualties

The US military has long operated under the assumption that the combat stress casualty must be distinguished from otherwise similar civilian and noncombat military stress cases with regard to assumptions about etiology and, by implication, treatment. Whereas the bio\psycho\social model presented above would generally apply to civilian or noncombat military situations of overwhelming stress, additional *intrapsychic* (ie, mental or emotional) dynamics are unique to the combat soldier (intrapsychic mental dynamics refers to the interaction of psychological functions in the mind, such as urges, pressure from the conscience, and the need to cooperate with the external world; intrapsychic conflict refers to clashes or tension that arise when two or more become seemingly incompatible or irreconcilable), and these may negatively influence his interpretation of the combat experience and increase his psychological vulnerability.^{34,51,52} These intrapsychic dynamics include:

1. He has been *trained to kill* (the enemy, as well as accept collateral damage) and, when necessary, is expected to do this without hesitation. This is more than the fact that he was trained to use deadly force as this would also be the case for law enforcement personnel. The specific mandate under which the infantry soldier operates, that is, his duty, is “to close with and destroy or capture the enemy.” This does not specify that his sole aim is to kill the enemy, but it sanctions that extreme measure as a principal tool, not one of last resort.
2. Consequent to his training to kill, he may bear substantial *moral/ethical* strain in overriding a

lifetime of socialization to not be destructive, especially not to kill. (Retired Army Ranger and former professor of psychology at the US Military Academy at West Point, Dave Grossman, makes this case convincingly in his review of the extensive historical documentation substantiating the average soldier’s resistance to kill. In fact, according to Grossman, the prospect that soldiers fighting in Vietnam would exhibit hesitancy in firing their weapons at the enemy was a problem the military took very seriously in conditioning troops for service in that conflict.³⁴) This strain could become heightened if combat circumstances take an unfavorable turn (ie, locally, should he and his unit encounter dire combat circumstances; or more broadly, as when the moral justification for his combat participation becomes questionable secondary to public opposition to the war). According to Stewart L Baker Jr, a senior Army psychiatrist, in earlier wars the role of “guilt about killing or assailing defenseless enemy personnel, either military or civilian . . .” was found to be an important precipitating factor for some combat reaction cases. (“In such instances . . . the superimposed military code yielded to the earlier and stronger civilian prohibition against violence against others.”^{7(p1834)})

3. He may also become *motivationally conflicted* in instances when (1) and (2) apply or when self-preserved instincts rise to a level where they oppose his sense of his duty to perform under fire and perhaps sacrifice his life for his countrymen. While under treatment these conflicts may become elevated by the soldier’s awareness that he is expected to recover and return to combat and face additional hazards.

According to Grossman, an especially pathogenic combination of factors can face a soldier and account for his becoming a combat reaction casualty (when compared to noncombatants):

Fear of death and injury is *not* (author’s emphasis) the only, or even the major, cause of psychiatric casualties in combat. . . . The whole truth is much more complex and horrible. . . .

[It is man’s natural] resistance to overt, aggressive confrontation, in addition to the fear of death and injury, [that] is responsible for much of the trauma and stress on the battlefield. . . .

Fear, combined with exhaustion, hate, horror, and the irreconcilable task of balancing these with the need to kill, eventually drives the soldier so deeply into a mire of guilt and horror that he [is overwhelmed].^{34(p54)}

Grossman also put a high valence on a sort of combat paranoia that contributes to soldier stress. ("The soldier in combat . . . resists the powerful obligation and coercion to engage in aggressive and assertive actions on the battlefield [because] he dreads facing the irrational aggression and hostility embodied in the enemy."^{34(p78)})

The following three cases from the 935th Psychiatric Detachment in Vietnam, all from the winter and spring of 1968, will serve as illustrations.

CASE 6-2: Acute Combat Stress Reaction With Fearfulness, Tremulousness, Social Withdrawal, and Aversion to More Combat

Identifying information: Private First Class (PFC) Golf was a 22-year-old infantryman with 5 months in Vietnam. He was brought in to the 93rd Evacuation Hospital with several casualties after a heavy firefight.

Past history: None recorded.

Examination: At the time of admission PFC Golf was described as mute, hyperalert, tremulous, and fearful. Physical exam was within normal limits.

Clinical course: He was put to sleep with Thorazine (no specifics) and mobilized the next morning. At that time he was morose, exhibited a little consciously determined posturing, and complained of stomach upset, pain, and fear of recurrence of an alleged ulcer. He talked about not wanting to fight anymore and being tired of "all the killing going on." He was alert and without evidence of psychosis. On the ward he remained quiet and somewhat seclusive. His attending psychiatrist wrote, "Although he continues to appear morose and a bit depressed, I strongly favor rapid remobilization of his functioning in an effort to prevent a more serious deterioration motivated by desire to be away from the combat situation." He was discharged back to his unit after 2 days of hospitalization.

Discharge diagnosis: Combat exhaustion, acute, moderately severe, improved. Impairment: moderate.

Disposition: Returned to full duty with a prescription for antacid medication.

Source: Discharge Summary, 935th Psychiatric Detachment/93rd Evacuation Hospital.

CASE 6-3: Acute Combat Stress Reaction With Rage After His Boat Was Ambushed

Identifying information: PFC Hotel was a 20-year-old married Roman Catholic infantryman with 11 months in the Army and 2 months in Vietnam. He was brought to the 93rd Evacuation Hospital from the field after the riverboat he was on was ambushed by the VC. History of present illness: During the attack an RPG [rocket-propelled grenade] round blew his buddy "to pieces," killed another, and wounded several more. PFC Hotel became angry and lost control.

Past history: None provided.

Examination: Patient was alert, tearful, and angry. He said, "We're dying for no purpose! Let me get back to my unit. I hate all VC." He was oriented and showed no signs of a thought disorder or any impairment of judgment or memory.

Clinical course: Sleep therapy for 20 hours with Thorazine. Appropriate on awakening. Able to discuss the episode. He was discharged back to his unit after an overnight stay.

Discharge diagnosis: Acute stress reaction, mild, improved. Impairment: minimal.

Disposition: Returned to duty by way of the division Mental Health Consultation Service.

Source: Discharge Summary, 935th Psychiatric Detachment/93rd Evacuation Hospital.

CASE 6-4: Acute Combat Stress Reaction With Fearfulness, Depression, Disorientation, and Mild Dissociation

Identifying information: PFC India was an 18-year-old infantryman with 8 months in the Army and 1 month in Vietnam. He was referred from the 9th Infantry Division Mental Health Consultation Service after he was evacuated by dustoff helicopter from the field.

History of present illness: When his unit came under heavy fire, he was observed to become stuporous, detached, frightened, and he removed his gear and ran around without regard for sniper fire. He kept repeating, “I didn’t want to kill anyone!”

Past history: None recorded.

Examination: At the division he was reportedly disoriented. At the 935th PFC India presented as a sad, preoccupied man with shortened attention span, impaired recent memory, and depressed and diminished manifest affect. He was disoriented for time and place. There was no evidence of a thought disorder.

Clinical course: He was given an 18-hour course of sleep treatment with Thorazine and then rapidly mobilized in the therapeutic milieu. His disorientation, impoverished affect, and other manifest symptoms cleared. Though his fearfulness of returning to the field persisted, his attending psychiatrist indicated that he was ready to return to duty. He was returned to his unit after 2 days hospitalization.

Discharge diagnosis: Combat exhaustion, acute, moderately severe, improved. Impairment: mild.

Disposition: Returned to duty by way of the division Mental Health Consultation Service with the recommendation that his commander should consider whether PFC India was reliable enough for combat duty.

Source: Discharge Summary, 935th Psychiatric Detachment/93rd Evacuation Hospital.

History of the Military Classification System for Combat Stress Reactions

The military has elected to use context-specific terms to refer to the psychiatric casualties of combat while the civilian community has sought increased comprehensiveness in psychiatric diagnosis. The adoption of uniquely combat-centered terms for this new type of casualty began during World War I because the civilian diagnostic system in use was more suited to the large mental hospitals in the United States.¹⁹ Shifts in nomenclature for combat stress casualties initially reflected revisions in assumed pathogenesis, and later, the gap between civilian-based medical priority of symptom removal versus military-based one of force conservation. The term *shell shock* was employed early in World War I because it was believed that a concussive injury to the brain was responsible. Subsequently, psychological terms like *war neurosis*, *combat neurosis*, and even *gas hysteria* were employed (the latter referred to soldiers who became incapacitated with respiratory symptoms despite there being no poison gas in the area). These labels served to characterize the affected soldier as suffering with a combat-provoked *intrapsychic* (ie, mental or emotional) conflict—an etiological proposition consistent with then popular Freudian theories.⁵³

In World War II use of the terms *combat exhaustion* and *combat fatigue* represented a pragmatic decision by the military in support of force conservation. Command directives specified that such terms replace those of neurosis as the latter could encourage soldiers to imitate the bizarre symptoms of stereotypical civilian psychiatric patients in order to be exempted from further combat.²³ As Glass noted, this was a salutary shift in that “although [exhaustion was] a non-specific and non-psychological term [it] was an apt description of a temporary fluid condition resulting from physical and emotional strain of combat, regardless of manifestations or predisposition.”^{23(p507)} Glass also indicated that the overall manpower losses for combat stress disorders declined following this change in labeling because “psychiatric casualties became legitimized as a rational consequence of combat circumstances.”^{23(p506)}

At the close of World War II, *combat exhaustion* was ultimately selected as the official term for combat reactions.^{54,55} The Joint Armed Forces Nomenclature (June 1949) placed “combat exhaustion” [3273] under “transient personality disorders.” By definition it was intended for “previously more or less ‘normal

persons,” applied to “transient,” potentially reversible, reactions in which the combat soldier “may display a marked psychological disorganization akin to certain psychoses,” and was “justified *only* (emphasis added) in situations in which the individual [was] exposed to severe physical demands or extreme emotional stress in combat”⁵⁵(§II[8]pp11–12) (in other words, it satisfied all five of the observable classic combat stress reaction elements presented in Exhibit 6-1). In less clear-cut instances the nomenclature recommended “acute situational maladjustment” [3274] be utilized (also under transient personality disorders).⁵⁵(§II[8]pp11–12) This system of categorization stood throughout the Korean War (1950–1953). In June 1963, the Armed Forces Medical Diagnosis Nomenclature and Statistical Classification (AR 40-401) became official.⁵⁶ It continued the use of “combat exhaustion” [3263] as well as “other acute situational maladjustment” [3264], and these categories carried throughout the Vietnam War (1965–1973). (Also see Exhibit 6-2, “Civilian Nosology and Combat Stress Reaction.”)

However, according to Glass, as the Vietnam War lengthened, the term *classical combat fatigue*, which had originally been coined as an all-encompassing term, had ironically become a myth, despite its having been codified in official diagnostic manuals. He was concerned that it was being utilized too strictly; that is, that underlying personality defects were being dismissed as etiologically irrelevant, and the only combat casualties counted as combat fatigue cases were the “relatively few individuals who possess a theoretically healthy psychic apparatus but are temporarily overwhelmed by extraordinary circumstances of trauma and deprivation.”⁵⁷(pxxv) Finally, to complete the picture of the evolving taxonomy for combat stress reactions, it is important to acknowledge the emergence of the posttraumatic stress disorder (PTSD) diagnosis in the decade following the end of the Vietnam War. As the popularity of this new diagnosis grew among both military and civilian psychiatrists, especially those serving veterans in the Department of Veterans Affairs, many professionals, as well as lay individuals, came to assume that this diagnostic entity was synonymous with combat exhaustion; however, this was not the case⁵⁸ (see Exhibit 6-3, “The Post-Vietnam Era and Posttraumatic Stress Disorder”).

VIETNAM: THE COMBAT ECOLOGY AND RELATED STRESSORS

As mentioned earlier, observation drawn from the main force wars leading up to Vietnam primarily emphasized two overlapping dimensions of modern warfare that can make it unbearably stressful and generate combat stress reactions in large numbers: (1) its intensity, that is, its lethality, which has historically been measured with the wounded-in-action (WIA) rate; and (2) how exhausting it is, that is, its strenuous and depleting nature, which has to some extent been objectively measured in terms of the duration of the soldier’s exposure; but in other regards it is not measurable because it can be experienced quite subjectively (see Figure 6-1). However, Vietnam was different in many ways from the wars that preceded it, especially in becoming a counterinsurgency/guerrilla conflict; consequently, comparisons with the combat reaction model from World War II and Korea that rest on these two dimensions may be only so useful.

The Combat Intensity (Lethality)

Variable in Vietnam

The designation of Vietnam as low intensity—a classification based on the low ratio of casualties to numbers of personnel deployed—appears to be somewhat misleading. Not only does the higher proportion of noncombat troops to combat troops in Vietnam alter the metric, but otherwise, as Spector, a military historian, convincingly argued using other measures, the fighting there was often as bloody as that seen in earlier wars. Combat Specimen #1: Viet Cong Ambush During the Battle of Dau Tieng (in Attachment 6-1) is excerpted from SLA Marshall’s *Ambush*⁵⁹(pp138–147) to illustrate Spector’s point. (This example of the reconstruction of a small unit action by Marshall was chosen because he employed a unique method of group battle debriefing that he devised in World War II.⁶⁰(pp108–115),61(p72))

The Combat Exhaustion Variable in Vietnam

If reduced combat intensity in Vietnam cannot account for the low incidence of classic combat reaction cases, consideration must be given to the other major variable: soldier exhaustion. To say that combat activities for the American infantry in Vietnam were not physically and psychologically arduous (and thus exhausting in the conventional sense) would also be

EXHIBIT 6-2. Civilian Nosology and Combat Stress Reaction

The civilian classification system for psychiatric disorders became increasingly complex during the second half of the 20th century and the opening years of this one. The first American Psychiatric Association *Diagnostic and Statistical Manual* (DSM-I) was published in 1952 and was based on a presumed pathogenesis for mental disturbances that emphasized intrapsychic motives and conflicts.¹ It included the entity “gross stress reaction,” which more or less replicated military psychiatry’s characterization of the combat (stress) reaction or CSR. This was because the establishment of the American taxonomy at that time was influenced by the many psychiatrists with military experience in World War II who had treated soldiers who developed disabling psychiatric symptoms from exposure to combat. (Later it would be the reverse, ie, that attitudes among civilian psychiatrists would come to influence the military’s approach to combat stress casualties.) Gross stress reaction (54.0) was listed as a subcategory of transient situational personality disorders, as was adult situational reaction (54.1). Gross stress reaction applied to situations of reversible symptomatology occurring among otherwise normal persons who sustained “conditions of great or unusual stress.” The diagnosis was considered to be preliminary and, should such cases not respond to prompt treatment, it was to be replaced with a more definitive one. Along with civilian catastrophes, DSM-I specifically included participation in combat as having the potential to produce intolerable stress. Yet it can be argued that, in lumping civilian (or noncombat military) conditions with those occurring on the battlefield, important psychodynamic assumptions regarding the pathogenesis of CSR were overlooked. Whereas gross stress reaction satisfied all five of the observable CSR criteria mentioned in Exhibit 6-1, to merge CSR with similar civilian casualties required the obviation of the unique intrapsychic features presumed to play an important role in many soldiers’ breakdown (or complicate recovery), that is, *trained to kill, moral/ethical strain, and motivational conflict*.

Taxonomic matters became more confused in 1968, roughly halfway through the Vietnam War, when DSM-II as well as ICD-8 (the World Health Organization’s *International Classification of Diseases, 8th Rev.*) were published following a process of synchronization. Although there had been earlier versions of the ICD, the 8th revision was the first one to include a psychiatric taxonomy to any extent.^{2(p435)} No longer listed was the specific category of gross stress reaction. Consequently it must be assumed that combat reactions were to be under transient situational disturbances/adjustment reaction of adult life (307.3), described as disorders “of any severity” (emphasis added) in reaction to “overwhelming environmental stress” in otherwise not predisposed individuals. Regarding etiology, combat exposure is not mentioned specifically, but the DSM-II did include the following as an example of adjustment reaction of adult life: “Fear associated with military combat and manifested by trembling, running, and hiding.”^{3(p49)} DSM-II suggests that the treatment for these conditions lies mostly in the simple removal of the stress. By implication, combat had become lumped in with experiences in which the individual is simply the victim of an unforeseen trauma, and the proposed treatment is removal from the battlefield. Clearly by 1968, experienced military psychiatrists had faded in their influence on American psychiatry. (Also see Exhibit 6-3, “The Post-Vietnam Era and Posttraumatic Stress Disorder.”)

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misleading. Combat Specimen #2: Patrolling the Rong Sat Zone, also provided by Marshall in *Ambush*^{59(pp187–192)} (in Attachment 6-2), describes conditions faced by Army troops operating in lowlands of the Mekong River delta in Vietnam. Clearly by that example, the task of eliminating the Viet Cong threat in the Mekong River delta was outrageously physically demanding, and thus psychologically challenging. However, it is noteworthy that, compared to their enemy counterparts, at least the American soldiers were regularly rotated out

of those conditions in order to recover body and spirit. And that is to the point: on the whole, soldiers fighting in Vietnam were less frequently exposed to *sustained* fighting than was typical in previous wars (Figure 6-2).

American technological superiority and the enemy’s inability to deliver precision-guided indirect fire as with artillery and combat aircraft dramatically reduced the dimension of fatigue for committed troops as they were less likely to get pinned down for prolonged periods (with the special exception in early 1968 of the 76-day siege

EXHIBIT 6-3. The Post-Vietnam Era and Posttraumatic Stress Disorder

As noted in Chapter 2, combat stress reaction (CSR) is often confused with posttraumatic stress disorder (PTSD).¹ In the decade following the end of the Vietnam War, the *Diagnostic and Statistical Manual of the Mental Disorders*, 3rd edition (DSM-III)² (1980) and the *International Classification of Disease*, 9th edition, Clinical Modification (ICD-9-CM)³ (1979) were published and included the new category “Posttraumatic Stress Disorder” (PTSD), which was initially referred to as “post-Vietnam syndrome.”⁴

According to DSM-III, PTSD (309.81) referred to “symptoms *following* (emphasis added) a psychologically traumatic event.”^{52(p236)} It applied to individuals who had experienced an event outside the range of usual human experience, which was accompanied by intense fear, terror, and/or helplessness, and which would be markedly distressing to almost anyone; and it included adverse combat events as having this potential. By these criteria alone, the new PTSD resembled the gross stress reaction of DSM-I. PTSD symptoms included variations of: (a) reexperiencing the traumatic event; (b) avoiding stimuli associated with the trauma or experiencing a numbing of general responsiveness; and (c) symptoms of increased arousal (eg, sleep difficulties, irritability, hypervigilance, exaggerated startle response, or increased physiological arousal upon exposure to events that symbolize or resemble an aspect of the traumatic event).

Notably, the revised version of DSM-III clarified that the PTSD diagnosis was not intended for individuals whose symptoms remitted within 1 month after the event.^{5(p435)} Thus, as defined by DSM-III, PTSD satisfied two of the aforementioned CSR diagnostic criteria: (1) exposure to *exceptionally stressful* (combat) *events*, and (2) *universal susceptibility*. However, the diagnosis of PTSD did not explicitly include *rapid deterioration* and *disabling regression* as associated phenomena. Furthermore, by excluding individuals whose symptoms lasted less than 1 month it explicitly did not satisfy the *reversible course* criteria for CSR. In other words, by these terms alone it was evident that PTSD was distinct from CSR.

Further distinguishing PTSD from CSR, DSM-III referred to delayed and chronic PTSD. Delayed PTSD was to be used when symptoms emerged after 6 months following the traumatic event; and chronic PTSD applied if the symptoms persisted 6 months beyond it. The first of these stipulations would negate the *rapid deterioration* criteria for CSR, and the second one would negate the *reversible course* criteria (presuming the individual had timely treatment in the field without effect). DSM-III was also confusing in that it assigned PTSD the number 309.8, which placed it in the category of adjustment disorders (which would satisfy the *universal susceptibility* condition for CSR); however, in the arrangement of psychiatric conditions in the schema, PTSD was placed among the “anxiety disorders” (or anxiety and phobic neuroses), which would suggest the opposite, that is, psychological predisposition.

of 5,500 defenders of the Marine base at Khe Sanh⁶²). Combat engagements with the enemy were more often intermittent, relatively brief (lasting minutes to hours; rarely days), and staged from well-defended enclaves that were easily resupplied by helicopter. Troops were also well supported through the tactical use of heliborne maneuver and artillery/air support.

On the other hand, the new heliborne capability of rapid, vertical assaults may have added a new means of exhaustion as it allowed troops to become engaged in more frequent contacts with the enemy over time compared to the soldiers from earlier wars who would get to the fight over the ground. It also meant that units could be sustained in place during intense, prolonged combat, which resulted in elevated combat stress levels. Air-mobile insertions in Vietnam were also very dangerous. The troops typically had to deploy from a hovering aircraft and make an exposed assault across an open clearing large enough for several helicopters.⁶³ (See Chapter 1 for an overview of the shifting stress-

generating and stress-mitigating factors that comprised the physical, social, and psychological combat “ecology” affecting ground forces in Vietnam.)

Additional Features Comprising the Combat Ecologies in Vietnam

As mentioned in Chapter 1, the United States and its allies faced a two-fold enemy in South Vietnam, each of whom employed different tactics and weapons: (1) the indigenous Viet Cong guerrilla forces employed harassment, terrorism, ambush, and psychological warfare (see Exhibit 1-1, “The Viet Cong Strategy of Terror”), and (2) the regular units of the North Vietnam Army (NVA) staged more conventional attacks from behind the safety of the 17th parallel/demilitarized zone (DMZ). Combat Specimen #1 may serve as an example of the former, but the variations in the sub-(combat) ecologies in South Vietnam should also be considered as each brought unique challenges for US forces. Colonel Matthew D Parrish, the third Neuropsychiatry

EXHIBIT 6-3. The Post-Vietnam Era and Posttraumatic Stress Disorder, continued

Peculiarly, DSM-III did not initially include the alternative to PTSD—acute stress reaction—that was listed in ICD-9-CM. However, DSM-III did include brief reactive psychosis, with combat listed as an etiologic event. This omission was rectified in the later iterations when DSM-IV⁶ (1994) and DSM-IV-TR⁷ (2000) added acute stress disorder or ASD (308.3) for symptoms in conjunction with intense fear, helplessness, or horror, that arise “*while experiencing or after experiencing the distressing event*” (emphasis added). Although the military nosology has conceptually embraced the acute stress disorder diagnosis, the doctrine for combat deployed troops has continued to utilize the term *combat stress* (currently *combat and operational stress reaction* [COSR]⁸).

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Consultant to the Commanding General, US Army Republic of Vietnam (CG/USARV) Surgeon (senior Army psychiatrist in South Vietnam), summarized some of the fundamental adaptational requirements:

[Under optimal circumstances] the infantry unit welds itself into a cohesive and effective team [while training for deployment in the United States]. These men maneuver and practice together until they are familiar, trusting, and nicely coordinated with each other. They study and do exercises needed for Viet Nam, [for example], in tunnel warfare, night infiltration, special fire discipline. They learn all about mines, punji sticks, booby traps, ambushes and enemy ruses. Only upon deployment in Vietnam and infused into its own target area, does the infantry team reach final maturity. Once there it seeks to become symbiotic with the jungle. Its individual soldiers coordinate quickly with each other in their response to communication with natives, to a change of jungle and village smells and sounds, or to the reactions of their dog and

his handler. The jungle becomes an extension of the men’s, of the team’s, organs of sense and locomotion, and the team becomes an extension of the jungle.

The brigade deploys now in forested plains north of Saigon. There one of the soldiers, who knows all about booby traps, finds a cigarette lighter, and it blows his hand off. His buddies, also trained in such matters, rush to his aid and a Claymore mine booby trap kills five of them. A soldier jumps across a ditch and onto a set of punji sticks under the leaves. A little girl walks in among the Americans in their camp. She is carrying a satchel charge. A company completely surrounds a village and fights its way in, but it finds only women and children. The Viet Cong [VC] has escaped by a tunnel or a little string of underbrush. Farmers, seemingly on freedom’s side by day, are VC by night. All of this the brigade already learned in the [United States], but they learn much of it again the hard way.



FIGURE 6-2A. Close aerial view of a fire support base of the 1st Cavalry Division, 1970. Such forward bases as this provided artillery support for combat operations and served as staging areas for ground maneuver elements that were typically moved around the battlefield by helicopter. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).



FIGURE 6-2B. Perimeter defenses of a 1st Cavalry Division fire support base. This photograph illustrates both passive (concertina wire and cleared vegetation) and active (.50 caliber machine gun emplacement) components in the perimeter defense of a firebase in 1970. Although the machine gun appears to be unmanned, undoubtedly the crew was close by. This reflects the Viet Cong practice of using the cover of darkness to initiate mortar and rocket attacks and attempts at infiltration using sappers (stealth commandos). Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).



[Top] FIGURE 6-2C. Primitive living conditions on a 1st Cavalry Division forward fire support base, 1970. The high heat and humidity, persistent threat of enemy attack, confined living quarters and limited personal amenities, and episodes of continuous operations combined to create high stress for those assigned to such isolated outposts. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).



[Middle] FIGURE 6-2D. Mess tent on a 1st Cavalry Division fire support base, 1970. The Army made every effort to make life on these remote outposts as tolerable for troops as possible. As food is always a critical morale-bolstering element, this especially included the provision of hot meals whenever possible. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).



[Bottom] FIGURE 6-2E. Soldiers playing chess during a lull in activities on a 1st Cavalry Division fire support base, 1970. This photograph illustrates how the dangers and sparse living conditions found on these isolated forward bases meant that troops had limited means to ward off long stretches of boredom and loneliness. Perhaps also insinuated by the picture is that the racial tensions of the era were less problematic in the field, where the shared goal of fighting a common enemy promoted cooperation and tolerance. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

Having cleaned up the plains, it moves confidently to the central highlands. There the weather is colder, wetter; the malaria is of a far more deadly type. The natives are mostly Montagnard, with ways of living and thinking completely different from the majority of Vietnamese. The enemy is not the VC but mostly the North Vietnamese regular army. There are few booby traps or tunnels. Many of the things the brigade is alert to no longer apply. One day an American company is following down a steep mountain trail. The platoons are fairly well spread out in a manner okay for the southern plains. Suddenly, in the thick woods, a North Vietnamese force fires into them. The Americans can't concentrate their platoons. The second company is too far back to move up through the mountainous forest. Air support is called in but the individual Americans have insufficient markers to show their position in this terrain. They're pinned down by their own air fire. Reinforcements come, but this enemy does not evaporate as the VC would. The Americans simply aren't with it yet in the central mountains. A few weeks later we find these same Americans traveling in different formation, alert to different clues, carrying more ammunition and more air signals. The NVA [North Vietnam Army] is getting hard to find. The brigade has begun to take over this terrain. They've become a part of it. If the brigade is now moved to the Delta they begin a new system, a fourth system. They must forge themselves into yet a different weapon.^{64(pp6-7)}

The Strain on Troops Fighting an Irregular War in Vietnam

Although Parrish portrayed a range of challenges facing combat troops under differing conditions, the psychological strain on conventional ground troops associated with fighting a mostly irregular type of warfare was never systematically addressed in Vietnam (Figure 6-3), at least not by military psychiatry. Such considerations would include the overall feature of serving in a combat zone in which there were no front lines, no deep rear area, and no location that was completely safe. It especially would include the challenge of chasing elusive insurgents, often repeatedly over the same ground, who nonetheless killed and wounded US troops using mines, booby traps, ambushes, sappers (infiltrating commandos), rocket and mortar attacks, or "the little girl with the satchel charge"—a strategy

specifically designed to demoralize combatants and noncombatants. Recall from Chapter 1 that fewer than 1% of US patrols conducted in 1967 and 1968 resulted in contact with the enemy—while the US casualty count steadily mounted.

Psychiatric observers underscored the fact that troops in Vietnam were not pinned down for long periods by artillery or automatic weapons fire, and that this spared them the depletion of soldier morale seen in earlier wars; however, it could be argued that a more subtle debilitation came from the steady attrition of troops from a mostly invisible and unpredictable enemy. Quoting Navy Lieutenant Stephen Howard, a Marine battalion surgeon, "Where [is there frank acknowledgement] of the blood, the death and pain, the fear in men tracking other men through an unknown jungle, and the stark terror of walking into an ambush or some other fierce danger?"^{51(p124)}

Doyle, Weiss, et al described the morally corrosive stressors affecting US combat troops in the theater as follows:

The strategy of terror employed by the Communists raised the level of savagery with which the war was fought and made the population of rural South Vietnam that much more negligible in the eyes of many who had come from so far away to protect them. Young and inexperienced, without adequate leadership, American fighting men encountered . . . an alien culture, a ruthless opponent, and a frequently indifferent, if not hostile, population. Instead of grateful civilians happy to be liberated, soldiers met sullen, suspicious people who regarded them as intruders and often seemed to conspire in their destruction. . . . For many men the source of terror became not simply the VC (Viet Cong) or NVA (North Vietnam Army), but "Nam" itself.^{65(pp155,157)}

As a corollary, the challenge for US troops to contain the urge to retaliate under these circumstances could be enormous. "For some men the pressure to act could become so unbearable that eventually any Vietnamese they encountered would serve as a necessary target."^{65(p155)} According to Balkind, a military historian, fighting an unconventional/counterinsurgency/guerrilla war naturally breeds a "habit" of undisciplined violence. Specific examples in Vietnam may be found in the periodic "mad minutes" (indiscriminate firing of weapons from the perimeter), reports of soldiers

“zippoing” villages (soldiers commonly carried Zippo cigarette lighters to the field), some soldiers decorating their uniforms with body parts of dead enemy as trophies, and instances of brutality toward civilians who were suspected of harboring the enemy or being their informants.^{66(p235)} More broadly, according to Spector, the casual abuse of designated “free-fire zones,” the high frequency of “unobserved” artillery and air support missions (areas where no specific target had been identified), and a general tendency for military overreaction all contributed to unacceptable and potentially counterproductive levels of collateral damage in Vietnam.^{67(p202)}

Individual Expressions of Excessive Combat Aggression in Vietnam

Excessive combat aggression refers to acts of violence that violate the principles of military necessity, discrimination, proportionality, and humanity, which are the basis of the law of war. In a survey conducted in 1989, 12% of Vietnam veterans reported they witnessed or participated in excessive combat aggression.^{67(p202)} In contrast, over the entire span of the war, there were only 242 US Army personnel formally accused of war crimes, with only 32 convictions. Additionally, 201 soldiers were convicted of serious crimes against Vietnamese civilians, including murder, rape, assault, mutilation of a corpse, and kidnapping.

These incidents were more common in the later years of the war, but otherwise, only about a quarter occurred during combat operations.⁶⁵ However, there is evidence to suggest that the problem was substantially underreported.^{65,67(p202),68–71} In their especially balanced historical review Doyle, Weiss, et al provided extensive corroboration (“atrocities did take place . . . from the casual to the deliberate, from horsing around to mass murder”^{65(p150)}). They also catalogued a broad collection of circumstances and stressors that promoted callousness among US combat troops. These can be roughly divided as to whether they were: (a) elements of the combat ecology in Vietnam; (b) structurally induced elements from outside the theater, which in turn influenced the combat ecology in Vietnam; or (c) a mixture of both:

(a) *Elements of the combat ecology in Vietnam*

- Encountering evidence of the systematic brutalization of Vietnamese civilians and officials by Viet Cong guerrillas

- Regular loss of combat buddies by mines, booby traps, snipers, sappers, rocket attacks, and ambushes
- The difficulty in distinguishing combatants from civilians
- Vast cultural differences between US troops and the rural population, which led to mutual mistrust and hostility
- Deteriorating morale as the war prolonged and resultant confusion among soldiers regarding what they were fighting for
- A “mere gook rule” in the field, that is, a belief shared by many that the deaths of Vietnamese did not matter, which helped justify a “shoot first and ask questions later” attitude
- A deficient reporting system for war crimes and a tendency to overlook them in the field

(b) *Structurally induced elements from outside the theater*

- Fielding mostly conscripted and very youthful troops (“Vietnam was a dangerous place to be struggling with issues of manhood and identity. Late adolescence is typified by recklessness, instability, and sexual uncertainty . . . and the war provided all too many opportunities for violent self-assertion.”^{65(p153)})
- Chronic personnel shortages
- The gradual lowering of the physical and intellectual induction standards consequent to retaining peacetime draft deferments (until 1970) and the military serving as “the employer of last resort”
- Abbreviated training cycles
- Boot camp indoctrination that encouraged racial hatred of Asians (referred to as “gooks,” “slants,” and “dinks”)

(c) *Mixed external and internal influences*

- Employing a strategy of enemy attrition versus one that pursued territorial control and pacification (through the first half of the war, combat success was measured in body counts and kill ratios, and many commanders employed both positive and negative incentives to increase their tally)
- Excessive turnover of experienced leadership personnel in the field, especially officers
- A cursory training in the Geneva Convention and casual enforcement of the theater Rules of Engagement

Nonetheless, Doyle, Weiss, et al did not conclude that US forces engaged in widespread brutality toward the Vietnamese nationals. ("For every instance of illegality and cruelty there were thousands more of courage and compassion. Heinous conduct was the exception, not the rule, taking place most often in poorly led units and in direct violation of existing policy."^{65(p150)}) They suggested that the worst offenders brought to the situation limitations in their intellect and personality or found themselves in unusual combat unit circumstances. (It should be further recognized that at least half of the items in their list of morale-depleting influences applied to all US troops serving in Vietnam, not just combat troops.)

THE PSYCHIATRIC LITERATURE FROM VIETNAM: OBSERVATION AND INTERPRETATION

The Apparent Low Incidence Level for Combat Stress Reaction Cases in Vietnam

The incidence rate for frank combat reaction cases appears to have remained low for the Army throughout the war. The first psychiatrist to indicate this trend was John A Bowman, who served early in the buildup phase (1966) as the first commander of the 935th Psychiatric Detachment. Although he reported that his KO team treated an array of anxiety-based symptoms, including conversion ("hysterical") symptoms, combat exhaustion was rarely seen (less than 2% of referrals). He attributed this to the fact that morale was high, combat was usually short-lived as the enemy typically did not choose to "stand and fight," adequate food and rest were usually available for the troops, and most cases were uncomplicated and effectively treated at the battalion aid stations.⁷² He also credited the fact that the troops (then) were "primarily Regular Army professional soldiers who were well-motivated and skillfully led."^{73(p59)} Bowman had little to say about the nature of the combat stress apart from the expectable fears of death or disfigurement. Soon, psychiatrists assigned to the Army combat divisions indicated that they also were seeing a low incidence for combat reaction, at least for classic combat exhaustion. They reported a range from seeing none⁷⁴ to treating only four to 12 per month,⁷⁵ with the higher numbers arising in 1967 and 1968.

Proposed explanations for the apparent low combat reaction incidence rate in Vietnam observed during

the first half of the war ranged across a list of stress-reducing preventive and operational features that were credited with making combat operations in Vietnam more psychologically tolerable despite the remote and challenging tropical setting and the enemy's terrorist/ guerrilla tactics and tenacity^{7,62,76-81}:

- the relative low intensity of the fighting, including its intermittent nature;
- the practice of staging combat activities from fixed, relatively secure and easily resupplied bases;
- the abundance of supplies, equipment, and support, including medical and psychiatric support;
- the relative low proportion of soldiers in Vietnam actually engaged in combat;
- American technological superiority, especially heliborne mobility;
- the professionalism of the troops;
- high-quality leadership; and
- fixed, 1-year assignments in the theater.

Problems in Documenting the Impact of Combat Stress in Vietnam

However, in reality the psychiatrists serving in the field were in a poor position to measure overall incidence rates for combat reaction because of the varying troop movements and evacuation procedures and the likelihood that many cases were effectively treated at the unit level or at the battalion aid stations and never seen by them.^{72,82-84} Harold SR Byrdy (1st Cavalry Division [Airmobile], 1965-1966) was the only division psychiatrist to report a combat reaction incidence rate for his division (1.6/1,000 troops/year). He commented:

Some cases of combat exhaustion were taken directly to the clearing hospital or to an evac hospital. For the less seriously disturbed, referrals often came when the units were recouping in the base camp. Referrals directly from the field were often for anxiety while from the base camp they mostly were characterological, as you'd expect. My point is, what gets referred [to the division psychiatrist] depends on the tactical situation of the unit involved, [consequently], one is hard-pressed to know what a real incidence is.^{85(p50)}

In the spring of 1967, Arnold W Johnson Jr, the second Psychiatry Consultant to CG/USARV, announced

that combat fatigue cases had remained infrequent for the initial 2 years of the war, with most being handled by the corpsmen and the battalion surgeons.⁸⁶ Parrish, his successor, concurred. He noted the attrition by combat-generated casualties in the theater was light, and that the combat stress symptoms seen were not the acute, disabling conditions seen in earlier wars but were more often milder, that is, tremulousness, insomnia, nightmares, severe somatic complaints, and startle reactions (between the normal combat reaction and the incipient/mild combat exhaustion in Table 6-1).⁸⁷

In fact, numbers for Army combat exhaustion cases were never systematically collected and analyzed, or at least the figures were not released, despite the fact that the deployed psychiatrists and the medical treatment facilities were explicitly required to forward monthly counts for inpatients with a combat exhaustion diagnosis to USARV HQ [See Appendix IV: USARV Psychiatry and Neurology Morbidity Report, in Appendix 2, “USARV Regulation 40-34”]. Regarding outpatients, William S Allerton, Chief, Psychiatry and Neurology Consultant Branch, Office of The Surgeon General (at the Pentagon), indicated that records of psychiatric outpatient contacts, irrespective of diagnosis, were not being collected in Vietnam,⁶ but this appears disputable based on a later psychiatric overview from the war.⁷⁶ More specific to combat exhaustion cases, following the war Stewart Baker indicated that, “There are no epidemiological projections for the number of [combat stress reaction (CSR)] cases not reaching [3rd echelon treatment facilities in Vietnam] or that have remained untreated [following the war].”^{7(p1837)} What seems evident in retrospect is that, at a central level, the Army Medical Department lost interest in the prevention, diagnosis, treatment, or management of combat reaction casualties in Vietnam, evidently because of their low numbers.

The only published summary of the US Army medical experience in Vietnam, which was limited to the first two-thirds of the war, did not include rates for combat exhaustion cases; in fact, it did not explicitly mention combat-generated psychopathology in any form or context.⁸⁸ The semiofficial overview of Army psychiatric experience in Vietnam, which was published after the war by Jones and Johnson, stated that the combat fatigue incidence rate throughout the war was “extremely low”; however, the authors provided no supporting data. Besides the fact that combat exhaustion incidence numbers were low, they acknowledged that

disagreements regarding diagnostic criteria impeded the collection and comparison of combat exhaustion statistics. (As an aside, Franklin Del Jones and Arnold W Johnson added some ambiguity by referring to *all* hospitalized psychiatric patients in Vietnam as “combat psychiatric casualties.”⁷⁶) This is consistent with William Hausman and David McK Rioch, both senior Army psychiatrists, who noted that during the Korean War, the term *combat exhaustion* was intentionally used to designate all combat-generated psychiatric casualties in order to minimize the damage to evacuees who might read their diagnoses.⁸⁹)

An alternative approach to measuring the impact of combat stress in Vietnam has been through noting the proportion of combat stress casualties found within total psychiatric diagnoses. The preliminary, semiofficial overview of Army mental health activities in Vietnam by Edward M Colbach and Matthew D Parrish, which also was limited to the first two-thirds of the war, reported that only 7% of all psychiatric admissions had been diagnosed as combat reaction. Unfortunately their report did not include data sources either.⁸⁷ This figure was very near to that of field research psychiatrist Peter G Bourne, who compared US Army psychiatric hospitalization rates in Vietnam with those of the Army of the Republic of Vietnam during the first year of the war and found 6% of psychiatric admissions to the Army hospitals in Vietnam (3rd echelon treatment facilities) were diagnosed as combat exhaustion.⁹⁰ (And Bourne bolstered his findings with a comment that “comparing the diagnostic compilation among the different Army facilities did not produce any marked inconsistency in diagnostic criteria.”⁹¹)

This figure for combat reaction, that is, 6% to 7% of all hospital psychiatric diagnoses, was reassuringly low; however, the metric could be misleading because it compared combat exhaustion casualties with other psychiatric disorders—conditions whose incidence could be based on different pathogenic variables (for example, the upsurge in use of illegal drugs in the second half of the war did not correlate with the overall decline in combat activity). It also understated the combat reaction attrition rate by only including cases hospitalized at 3rd echelon facilities in Vietnam (Army-level hospitals). Because, by definition, combat exhaustion is typically a reversible, stress-generated psychological regression that, when treated early and effectively, typically remits within a couple of days, many cases would be treated early and at lower

echelons of medical care by primary care physicians (general medical officers [GMO]) and thus not be included in psychiatric statistics.^{6,82,92}

The exceedingly low number of soldiers who warranted out-of-country medical evacuation for combat exhaustion was also a form of measurement of the low medical impact on the force for combat stress casualties. Among Army soldiers evacuated through Travis Air Force Base, California, between January 1967 and June 1967, 6.7% had psychiatric transfer diagnoses, but only one case of combat exhaustion was reported.⁹³ Similarly, Rorschach testing was administered to 1,500 soldiers with psychiatric diagnoses who were evacuated from Vietnam to the US Air Force Hospital, Clark Air Force Base, Republic of the Philippines, over a 2-year period early in the war. Only two of these cases produced results unambiguously consistent with a diagnosis of traumatic neurosis (defined by the author as a syndrome originating in an adequately functioning person and contracted acutely while the soldier was engaged in combat and in realistic danger of losing his life).⁹⁴

Estimating the Army Combat Reaction Incidence Rate in Vietnam for 1967

One approach for estimating the incidence rate for combat stress reaction (CSR) cases for the Army in Vietnam, at least for 1967, is through utilizing the only two reports that include theater-wide data regarding CSR cases (Table 6-2):

1. The 1967 incidence rates for CSR cases treated at 1st and 2nd medical echelon levels can be roughly estimated using William E Datel and Arnold W Johnson Jr's survey of outpatient psychotropic drug prescription patterns in Vietnam⁹⁵ (3.8 and 1.3 CSR cases /1,000 troops/year, respectively). (A description and summary of the Datel and Johnson study is in Chapter 7.)
2. The CSR incidence rate for cases treated at 3rd echelon medical treatment facilities (Army-level hospitals) in Vietnam in 1966 can be reasonably calculated using the aforementioned Bourne study.^{90,91} The resultant rate of 0.66 CSR cases per 1,000 troops per year for 1966 provides a basis for a rough estimation of the CSR incidence rate for 3rd echelon medical treatment facilities for 1967 by comparing the combat intensity in 1966 against that for 1967 (as measured by the wounded-in-

action rate—the traditional measure of combat intensity). The result is an estimated rate for 3rd echelon hospitals for 1967 of 0.89 CSR cases per 1,000 troops per year.

3. Summing the two CSR rate figures from (1), that is, 1st echelon care as 3.8 and 2nd echelon care as 1.3, and the 3rd echelon CSR rate figure from (2), that is, 0.89, provides a reasonable estimate of the incidence rate for CSR cases among Army troops in Vietnam in 1967: 6 CSR cases per 1,000 troops per year.

Thus, by these estimates, for every case of combat stress reaction in 1967 there were 17.5 soldiers wounded in action (ie, the wounded-in-action rate of 105.1/1,000 troops/year divided by the estimated CSR incidence rate of 6 CSR cases/1,000/year). It can be further noted that this ratio, 1 CSR:17.5 WIA, is far lower than the predicted rate of 1:4, which was based on pre-Vietnam combat experience.¹

Estimating the Overall Army Combat Reaction Incidence Rate in Vietnam

Although it requires successive approximations, the 1967 theater ratio of 1 CSR per 17.5 WIA can be used to approximate the Army CSR incidence rates in Vietnam for each year of the war. Table 6-3 presents the Army WIA rates for each year of the war and applies the ratio of 1 CSR per 17.5 WIA to calculate the corresponding annual CSR rate estimates. The mean for these eight yearly CSR incidence rates is 5.4 cases per 1,000 troops per year.

Despite the paucity of actual CSR incidence data, ambiguities as to how combat exhaustion was defined by Army physicians in Vietnam (most of whom were not trained in psychiatry), and shortcomings in the data used in these calculations, 5 to 6 CSR cases per 1,000 troops per year for the war represents a crude but reasonable estimate of the overall CSR incidence rate for the Army in Vietnam. Still, if the ratio of 1 CSR per 17.5 WIA approximates the reality in Vietnam, and if, in fact, Army Medical Department planners applied the 1 CSR:4 WIA rule of thumb from the pre-Vietnam high-intensity wars, they would have overestimated the actual CSR incidence rate for Vietnam by a multiple of 4 to 4.5 (17.5 divided 4). As a corollary, by these estimates, the risk to any one soldier of developing CSR in Vietnam was 22% to 25% of that found in the high-intensity wars preceding Vietnam.

TABLE 6-2. Estimated and Predicted Combat Stress Reaction Rates in Vietnam, 1966 and 1967

ESTIMATED CSR RATES IN VIETNAM	1966	1967
1st Echelon Care Settings: Treatment by nonspecialized battalion surgeons and medics (at Battalion Aid Station, Dispensaries)	[No data]	Derived from Datel and Johnson ¹ : Cases treated in June = 44 “Soldiers-at-risk” = 138,900* Estimated 1st echelon CSR rate = 3.8 (44/138.9 X 12 months)
2nd Echelon Care Settings: Specialized treatment by division psychiatrists and allied psychiatric personnel at the division clearing company	[No data]	Derived from Datel and Johnson ¹ : Cases treated in June = 9 [†] “Soldiers-at-risk” = 85,700* Estimated 2nd echelon CSR rate = 1.3 (9/85.7 X 12 months)
3rd Echelon Care Settings: Specialized treatment at evacuation or field hospitals and psychiatric specialty detachments (KO teams)	Data derived from Bourne ² : CSR cases hosp in 1st 6 mo. = 46 Mean Army strength in 1st 6 mo. = 138,900 ³ Estimated 3rd echelon CSR rate = 0.66 (46/138.9K X 2)	[No data] Extrapolated from 1966 Bourne data ² : 1966 hospital level CSR rate = 0.66 Estimated 3rd echelon CSR rate = 0.89 (0.66 X 1.35 [‡])
PREDICTED CSR RATE FOR VIETNAM	1966	1967
WWII/Korea Rule of thumb: “1 CSR to 4 WIA” ⁴	US Army in Vietnam = 239,000 ⁵ Army WIA = 18,568 ⁶ WIA rate (ie, combat intensity) = 77.7	US Army in Vietnam = 319,500 ⁵ Army WIA = 33,572 ⁶ WIA rate (ie, combat intensity) = 105.1 Predicted CSR rate = 26.3 (.25 X WIA rate)

Note: US Army combat stress reaction incidence rate in Vietnam as estimated for 1967 and compared with a predicted rate derived from World War II and Korea. All rates are per 1,000 troops per year.

*“Soldiers-at-risk” refers to investigators’ estimates of the population of soldiers cared for by the Army 1st echelon primary care physician study participants; and by the Army psychiatrist study participants who provided 2nd echelon, that is, outpatient, care.

[†]Nine represents three-fourths of the 12 CSR cases treated. Of the eight psychiatrist respondents, six were Army psychiatrists (thus deleted were the three cases estimated to have been treated by the two Navy psychiatrists assigned to the Marines in Vietnam).

[‡]1.35 is the 1967 WIA rate (105.1) divided by that for 1966 (77.7)

Data sources: (1) Datel WE, Johnson AW Jr. *Psychotropic Prescription Medication in Vietnam*. Alexandria, Va: Defense Technical Information Center; 1981. Document No. AD A097610; (2) Bourne PG, Nguyen DS. A comparative study of neuropsychiatric casualties in the United States Army and the Army of the Republic of Vietnam. *Mil Med*. 1967;132(11):904–909.; (3) US Department of Defense. *Number of Casualties Incurred by US Military Personnel in Connection With the Conflict in Vietnam as the Result of Actions by Hostile Forces (January 1, 1961–December 31, 1973)*. Washington, DC: OASD (Comptroller), Directorate for Information Operations; 15 March 1974; (4) Cooke ET. *Another Look at Combat Exhaustion*. Fort Sam Houston, Tex: Department of Neuropsychiatry, Medical Field Service School; distributed July 1967. Training Document GR 51-400-320, 055; (5) US Department of Defense. *US Military Personnel in South Vietnam 1960–1972*. Washington, DC: OASD (Comptroller), Directorate for Information Operations; 15 March 1974; (6) US Department of the Army. *Active Duty Army Personnel Battle Casualties and Non-Battle Deaths Vietnam, 1961–1979*. Washington, DC: Office of The Adjutant General Counts, US Army Adjutant General, Casualty Services Division (DAAG-PEC). 3 February 1981.

CSR: combat stress reaction

WIA: wounded in action

WWII: World War II

TABLE 6-3. Estimated Annual Combat Stress Reaction Incidence Rates Utilizing US Army Vietnam Wounded-in-Action Incidence Rates and the Estimated Rate for 1967 (Table 6-2)

	1965	1966	1967	1968	1969	1970	1971	1972
US Army WIA rates (ie, combat intensity)*	30.1	77.7	105.1	166.3	152.9	100.7	65.0	52.6
Estimated CSR rates (WIA rate/17.5)	1.7	4.4	6.0	9.5	8.7	5.8	3.7	3.0

Data sources: (1) US Department of the Army. *Active Duty Army Personnel Battle Casualties and Non-Battle Deaths Vietnam, 1961-1979*.

Washington, DC: Office of The Adjutant General Counts, US Army Adjutant General, Casualty Services Division (DAAG-PEC); 3 February 1981;

(2) US Department of Defense. *US Military Personnel in South Vietnam 1960-1972*. Washington, DC: OASD (Comptroller), Directorate for Information Operations; 15 March 1974.

CSR: combat stress reaction

WIA: wounded in action

*Calculated from: Total WIA numbers¹ divided by annual Army troop strength in Vietnam.² All rates are per 1,000 troops/year.

Although these calculations are based on the best available data, they could be misleading for the following four reasons:

1. There may have been some overestimation of the CSR incidence rate in Vietnam because of the possibility of case duplication, that is, during the month time frame for the Dattel and Johnson study, some cases seen in lower echelons may have been passed up the evacuation chain and counted again. At the level of primary echelon care (versus secondary echelon care), this error seems minor as the Dattel and Johnson study reported that 97% of combat exhaustion cases treated by primary care physicians responded satisfactorily to treatment. With regard to secondary echelon care (vs tertiary echelon care, ie, hospitals), this error may have been larger because, although the survey was limited to outpatients, Dattel and Johnson indicate that they were not certain the six Army psychiatrists in the survey always limited their responses to experiences with outpatients.
2. Alternatively, some underestimation of the CSR incidence rate may have occurred because, whereas in past wars casualty rates (whether physical or psychiatric) have been calculated using overall Army troop strength in the theater, in Vietnam combat support and service-support troops outnumbered combat arms troops by perhaps as much as 3 to 4:1.
3. There may have also been some underestimation of the CSR incidence rate because these calculations
4. only pertain to soldiers who were seen by Army physicians, including psychiatrists. There were undoubtedly many soldiers with degrees of combat reaction who were effectively treated by buddies, unit cadre (including chaplains or enlisted corpsmen), or who simply withstood their symptoms, pressed on, and were never counted.

The fact that the psychiatrists and other Army physicians deployed in Vietnam were not provided operational guidelines for making the diagnosis could also contribute to a measurement error. The USARV regulation governing the provision of mental health care in Vietnam did indicate that combat exhaustion was a stress reaction, but it referred ambiguously to civilian texts for specific diagnostic criteria (see Appendix IV—USARV Psychiatry and Neurology Morbidity Report, in Appendix 2, “USARV Regulation 40-34”). This omission is similar to the vagueness in a handout distributed to newly inducted physicians on combat exhaustion during their 5-week training at the Army’s Medical Field Service School (MFSS). The MFSS faculty defined combat exhaustion as “an acute situational reaction from the stress of battle that renders the soldier ineffective,” and they alluded to the “wide range and intensity of symptoms” seen in combat exhaustion—based primarily on etiologic assumptions of “fear and exhaustion” and driven by the natural tendency for soldiers to manifest symptoms as a “passport” to the rear—but the training participants were

EXHIBIT 6-4. Progressive Stages of Combat Exhaustion

1. *Normal combat reaction*: applied to soldiers who could tolerate stress reaction symptoms. Danger signs indicating a soldier was reaching his tolerance limit were lack of appetite, inability to sleep, increasing irritability, and a decrease in judgment capability.
2. *Mild combat exhaustion*: applied when he could no longer function as an adequate combat soldier (predicted to be 80% of combat exhaustion cases referred to the battalion aid stations).
3. *Moderate combat exhaustion*: applied when he could no longer assume the responsibilities of a soldier in any capacity, much less in combat (predicted to be 15% of combat exhaustion cases referred to the battalion aid stations).
4. *Severe combat exhaustion*: applied when he could no longer function as a person, much less as a soldier (predicted to be 5% of combat exhaustion cases referred to the battalion aid stations).

Adapted from: Cooke ET. *Another Look at Combat Exhaustion*. Fort Sam Houston, Tex: Medical Field Service School, Department of Neuropsychiatry; 1967: 156. Training document GR 51-400-320, 055.

evidently expected to seek out diagnostic criteria on their own. (“The . . . symptoms noted in soldiers with combat exhaustion would fill many additional pages. Any standard reference will give a multitude of examples. The delineation of specific patterns will not receive further attention.”^{1(p9)}) However, MFSS did include a simplified, albeit very general, set of operational criteria regarding combat reaction stages (Exhibit 6-4)¹—a taxonomy that coincided with the combat reaction symptom spectrum from World War II presented in Table 6-1.

The fact that these potential errors appear to be offsetting may help to reinforce this belated approach to the measurement of the clinical impact of combat stress for the Army troops fighting in Vietnam.

Challenges in Making the Diagnosis of Combat Reaction in Vietnam

As noted, complicating the measure of the incidence rates in Vietnam for combat reaction were apparent variations in diagnostic criteria used by the Army psychiatrists in the field (Table 6-4). In fact, to diagnose combat exhaustion in Vietnam the psychiatrists and primary care physicians would have had to draw upon their pre-Vietnam experiences with acute stress reactions or extrapolate from the civilian taxonomy represented in the American Psychiatric Association’s *Diagnostic and Statistical Manual* (DSM-I, succeeded by DSM-II in 1968—see Exhibit 6-2, “Civilian Nosology and Combat Stress Reaction”).

There is one exception regarding the dearth of military-centered combat reaction diagnostic guidelines in the theater: in early 1967, Johnson published a timely article in the *US Army Vietnam Medical Bulletin* (“Psychiatric Treatment in the Combat Situation”²²) that reviewed the combat reaction diagnostic criteria and the Army’s forward treatment doctrine. This may have been disseminated in Vietnam in 1967 when it was published; however, it was not systematically distributed to those who were subsequently assigned over the next 5 years.

Observations Regarding Combat Reaction Presentations and Pathogenesis in Vietnam

The following review of the reported experiences of the Army psychiatrists deployed in Vietnam is extracted from the material presented in Chapter 3 and Chapter 4.

Division (“Combat”) Psychiatrists

Table 6-4 presents a summary of the various diagnostic taxonomies for combat reaction that were pragmatically devised by the division psychiatrists who provided 1st and 2nd echelon specialized care in Vietnam (ie, those who saw such cases and who provided a record). In addition it includes their impressions regarding pathogenic influences.

It is evident that the division psychiatrists had diverse experiences and that they were drawn to highlight differing diagnostic features among psychiatrically affected combat troops. It is also apparent they were not generally able to distinguish between the

TABLE 6-4. Summary Of Division Psychiatrists' Combat (Stress) Reaction Diagnostic Groupings, Criteria, and Impressions Regarding Pathogenic Factors

Psychiatrist Unit and Year	Combat Stress Reaction (CSR): Categories and Criteria	Pathogenic Factors
Byrde 1st Cavalry Division 1965-1966	Combat exhaustion: Disorganizing anxiety in reaction to combat situation (not in anticipation of combat). Symptoms must remit under the CSR treatment doctrine in order to retain diagnosis	Cumulative combat stress over time Comorbid psychiatric conditions Breakdown in combat group integrity Green sergeants leading seasoned troops "Short-timer's"
Bostrom 1st Cavalry Division 1967-1968	1. Normal combat syndrome—included "realistic anxiety" with increased physiological arousal but without degraded effectiveness 2. Precombat syndrome—included greater anxiety, sleep problems, psychosomatic complaints (nausea, tension headache, exaggerated musculoskeletal symptoms, reduced combat effectiveness) 3. Combat exhaustion—included psychosis or near psychosis, with gross loss of combat effectiveness	No specifics
WL Baker 9th Infantry Division 1967	1. Transient (combat) anxiety reaction—with hyperventilation and functional GI symptoms; in early months; in light combat 2. Classic combat fatigue—increased anxiety, regression (some with brief psychosis), and some degraded effectiveness 3. Modified combat stress reaction—disabling anxiety, GI disturbances (anorexia, nausea, "dry heaves"), hypervigilance, insomnia, combat trauma dreams, "short-timer's" syndrome (feels impending doom, "outlived the odds")	Increased combat activity/intensity, cumulative over time Traumatizing turning point (buddy lost; wounded) Breakdown in combat group integrity (from heavy combat losses; command transferred soldiers to other units to spread DEROS dates ["infusion"]) "Short-timer's" and 10 mo. veteran
Pettera 9th Infantry Division 1967-1968	1. Transient (combat) anxiety reaction—"nebulous, ill-defined"; recovered with supportive therapy 2. Combat fatigue—acute, severely incapacitating psychological reaction: anxiety, uncontrollable crying, hyperventilation, "clutching and freezing" 3. Vietnam combat reaction/"combat neurosis"—severely incapacitating psychophysiologic reaction: anxiety, tremulousness, GI disturbances (anorexia, nausea, vomiting, diarrhea), insomnia, combat trauma dreams, survivor guilt or shame for loss of control	1. "Little or no specific etiology" 2. Consequent to emotional and especially, physical fatigue from sustained combat exposure 3. Always developed from: repeated, severe combat trauma; a serious wound; or unit overrun. Only seasoned combat soldiers approaching DEROS were affected.
Motis 4th Infantry Division 1967-1968	Acute combat reaction—Types: Dazed, disoriented, exhausted, unresponsive, flat affect, hypokinetic ("I can't take it any more.") Hysterical, panicky, as if reliving a traumatic experience Anxious secondary to near-miss	Sustained, fierce fighting Extreme physical fatigue Surviving a near-miss
Bey 1st Infantry Division 1969-1970	1. Situational (combat) reaction—treatable at battalion aid station 2. Combat exhaustion—combat trauma dreams, anorexia, problems with concentration 3. Conversion/dissociation reaction	Individual: Posttraumatic reaction; Frightful reaction to first firefight Group: Unit rejects new member
Alessi 23rd Infantry Division 1970-1971	Nonpsychiatric emotional problem—"normal anxiety": headaches, abdominal cramps, sleep disturbance, poor appetite, fear of the field, combat refusal Psychophysiologic reaction—panicky, hyperventilation, syncope, vomiting, incontinence, headaches, freezing up, sleepwalking, "nerves," conversion pains	No specifics

GI: gastrointestinal

DEROS: date expected return from overseas

pathogenic variables outlined in Figure 6-1. Moreover, the available record suggested that so-called classic or uncomplicated combat exhaustion cases were overshadowed by those that were pathogenically more involved. Although the reporting psychiatrists did not provide full case examples, the following case material was provided by Specialist 6th Class Dennis L. Menard, an enlisted social work/psychology specialist, who served with the 1st Infantry Division (1967) and treated the patient in collaboration with the battalion surgeon.^{96(pp51-52)}

CASE 6-5: Tanker With Anxious Incoherence (Acute Stress Reaction) After His Tank Was Hit by an RPG

Identifying information: PFC Juliet is a 21-year-old, single enlistee who was dusted off via a medical evacuation helicopter from a forward area after a rocket-propelled grenade hit his tank. Upon arrival at the clearing station he was somewhat incoherent and hyperventilating and repeating, “I’ll be all right.” At first it was thought that he had physical injuries, but upon examination it was concluded that he was in an anxiety state. He was treated with an injection of 50 mg of Thorazine, IM. In the morning he was sent to the MHCS [mental health consultation services] in full uniform.

History of present illness: The patient vaguely recalled yesterday’s incident. He remembered seeing a flash, hearing shrapnel fly by his head, and seeing his tank commander attempt to pull him out of the crippled vehicle. This patient has been on line for approximately 7 months as a tank crewman and driver and has functioned well thus far. However, over the past months he has been under considerable strain as his unit has been having enemy contact daily. As a result of the physical hardships of constant moves, lack of sleep, and hard work, the entire troop was keyed up and was “nothing but a bundle of nerves.” Regarding yesterday’s action, the patient indicated he had been through “much worse.” For example, he has run over a few mines, has been sniped at frequently, and was in a 7-hour battle once in which his tank was immobilized on a hillside slope. After expending all the tank’s ammunition, the patient and his crew fought off the hostile force with .45 caliber pistols until help finally arrived.

Past history: PFC Juliet was born and raised in the upper Midwest as the oldest of five children. The domestic environment was described as stormy and chaotic. His mother, a cancer victim, and his father, a diabetic, fought constantly. At age 16, while attending the 11th grade, he left home and began a life of crime. Ultimately he was apprehended and offered the choice of joining the Army or going to jail. His troubled past notwithstanding, he adjusted well to Army life and completed both BCT [basic combat training] and AIT [advanced individual training] satisfactorily. He was assigned to Fort Benning as a weapons instructor where he stayed for 9 months before coming to Vietnam. He adjusted well in Vietnam and did his job with no qualms. After the above-mentioned firefight he was demoted because he failed to unload his pistol upon returning to base camp. Otherwise he has gotten along well with his crew, subordinates, and superiors.

Examination: At the mental health consultation service he presented as alert, attentive, coherent, and oriented with no signs of suicidal ideation, depression, hallucinations, or a thought disorder. He was mildly anxious and apprehensive. Insight and judgment appeared adequate.

Clinical course: The patient was reassured that he had sustained a normal reaction to having been in prolonged combat, and that it would be temporary with no lasting effects.

Discharge diagnosis: Combat exhaustion syndrome, moderate, manifested by an acute anxiety attack. Taken in consideration is his sustained combat performance and the fact that his unit has been under prolonged hostile harassment resulting in everyone sustaining physical and mental exhaustion.

Disposition: He was returned to full duty following his interview. [Addendum: Because of his injuries he was awarded the Purple Heart. It was reported that in the 4 months until his DEROS (date expected return overseas) he continued to function well.]

Source: Adapted from Menard DL. The social work specialist in a combat division. *US Army Vietnam Med Bull.* 1968;March/April:51-52.



FIGURE 6-3. Wounded Vietnamese children at a US Army hospital in Vietnam, 1970. These children, who are undergoing treatment for war wounds, are a reminder of how the Viet Cong utilized a strategy of terror that included systematic, deliberate attacks on South Vietnam civilians resulting in the death or injury of tens of thousands of noncombatants. From the standpoint of the war's psychological impact on the conventional US troops who fought there, the strain of engaging in irregular psychological warfare against determined guerrillas who employed such tactics apparently included a high potential for demoralization and associated psychiatric and behavioral problems (and in some instances, provoking retaliation and atrocities). Photograph courtesy of Norman M Camp, Colonel, US Army (Retired).

[Author: In retrospect it seems evident that a possible contributing etiologic factor would be that of a traumatic brain injury.]

Hospital and KO Team (“Hospital”) Psychiatrists

Evacuation and Field Hospitals Without a Psychiatric Detachment. Overall, the available reports from psychiatrists assigned to the field and evacuation hospitals without psychiatric specialty detachments suggest they treated relatively few fresh combat reactions. They also offered little about diagnostic criteria or contributory stresses. This is not surprising because these facilities were not organized to serve as the definitive treatment settings for soldiers in the combat units. Robert E Huffman (8th and 3rd Field Hospitals, 1965–1966) noted that 8% of his patients had combat stress as an etiologic factor; however, his greater numbers most likely stemmed from the fact that he was assigned in Vietnam before the psychiatric specialty detachments arrived to serve as 3rd echelon treatment facilities. John A Talbott (3rd Field Hospital, 1968) was equally anomalous. He reported seeing six combat reactions among 100 consecutive referrals, but these were primarily service-support troops reacting to fighting in and around Saigon during the Tet offensives. Neither Huffman nor Talbott commented on diagnostic criteria or contributory stresses. William F Kenny (17th Field Hospital, 1966) and Arthur S Blank Jr (3rd Field Hospital, 1966), both of whom were located in Saigon, said that they saw almost none. Gary L Tischler (67th Evacuation Hospital, 1966–1967) indicated that he saw some soldiers affected by combat stress, short-timer’s syndrome, and combat aversion, but his catchment area (Qui Nhon) was mostly composed of noncombat units too, and his report primarily centered on general patterns of stress and adaptation. The one case vignette of a combat soldier provided by Tischler does not include the element of exhaustion. Although he was an airborne soldier who had seen heavy enemy action over his 7 months in Vietnam, his disabling anxiety and paranoid symptoms arose on his return from R & R (rest and recuperation) and centered on his apprehension about resuming his combat role (“killing and being killed”), guilt from having survived several of his buddies, and feeling estranged from his unit’s new commanding officer (CO) and recent replacements (ie, as “the only old timer”).⁴⁷

Psychiatric Specialty Detachments/KO Teams.

The Army’s two specialized psychiatric detachments were intended to serve the combat units (along with

noncombat units); however, they were not organized to treat large numbers of direct admissions from the field because they were primarily expected to provide secondary and tertiary echelon care. CSR cases should have been treated first at 1st and 2nd treatment echelons within the divisions (battalion aid stations and brigade clearing companies), with the specialized psychiatric detachments serving as backup for soldiers who failed to recover. Bowman, the first commander of the 935th KO team (Long Binh post near Saigon), reported that fewer than 2% of their referrals in 1966 received a diagnosis of combat exhaustion (as mentioned earlier). His staff used two criteria for making the diagnosis: (1) actual exposure to combat, that is, under hostile fire, and (2) the presence of fatigue, whether produced by physical causes such as exertion, heat, dehydration, diarrhea, and loss of sleep, or by psychological causes such as anxiety and insomnia. Louis R Conte, the first commander of the 98th KO team (Nha Trang, 1966–1967) around the same time indicated that they saw even fewer.

Two years after Bowman and Conte, combat intensity in Vietnam rose sharply and, as H Spencer Bloch reported, 5.7% of the caseload of the 935th KO team was diagnosed with combat exhaustion. Bloch defined combat exhaustion as a syndrome that represented a stress-induced psychotic reaction with both external precipitating factors (including sleep deprivation, traumatic events, and possibly poor nutrition) and internal predisposing factors (including the inability to tolerate hostile feelings, anxiety associated with increased responsibility, or a strict conscience). In other words, he advocated the bio\psycho\social etiologic model alluded to earlier. However, because he and his team were working in a 3rd echelon treatment facility, they were often treating the more intractable cases, which would include soldiers with a greater degree of contributory personality susceptibility. The following case exemplifies a relatively uncomplicated combat exhaustion case that was a direct admission from the field to an evacuation hospital/KO team:

CASE 6-6: Acute Combat Stress Reaction With Psychomotor Retardation, Fearfulness, and Traumatic Dreams

Identifying information: PFC Kilo was a 20-year-old rifleman with 9 months in the Army and 3 months in Vietnam. He volunteered to serve in Vietnam.

History of present illness: On the day of his admission, two friends were killed. Also, he was to get on a dustoff flight but didn't, and the helicopter crashed. He has since become fearful of returning to the field. He was referred to the 935th Psychiatric Detachment/93rd Evacuation Hospital.

Past history: He reported having had prescient dreams of the deaths of an uncle and some friends in the past.

Examination: PFC Kilo presented as stunned and fearful. He had marked psychomotor retardation and fearfulness. In a monotonous voice he repeated, "Charlie killed my buddies," and cried and moaned without tears. He was fully oriented and acknowledged being more frightened than angry or sad. He told of having dreams of his own death and that of others, although he denied being superstitious. Physical exam was unremarkable.

Clinical course: The patient was encouraged to ventilate and then put to sleep with Thorazine for 18 hours, after which he was mobilized in the therapeutic milieu. He socialized well in the ward activities. He was held another day and began to express the desire to rejoin his unit, although he remained apprehensive about his dreams.

Discharge diagnosis: Combat exhaustion, acute, moderately severe. Stress: loss of buddies in combat. Predisposition: mild. Condition at discharge: recovered.

Disposition: Returned to full duty after 2 days of hospitalization; to be followed by the division psychiatrist.

Source: Narrative Summary, 935th Psychiatric Detachment/93rd Evacuation Hospital.

The next case is etiologically more complicated and the length of the hospitalization is greater. The therapeutic milieu is the primary treatment modality, along with time. Although the discharge diagnosis was that of a neurotic dissociative reaction, contemporary thinking would wish to rule out a traumatic brain injury as well despite the negative neurological evaluation.

CASE 6-7: Dissociative/Factitious Disorder Following a Friendly Fire Near Miss

Identifying information: Sergeant (SGT) Lima was a 21-year-old with 3 years service in the Army and 24 months in Vietnam who was hospitalized at the 935th Psychiatric Detachment/93rd Evacuation Hospital.

History of present illness: The patient was initially kept overnight at his brigade clearing company after he developed a stunned, mute state in conjunction with a friendly fire incident in which an American bomb landed close to his position. A neurological exam was within normal limits. The following day he appeared coherent but indicated a retrograde amnesia, including for the events of the previous day.

Past history: The record only indicates that he had similar episodes previously (no details).

Examination: SGT Lima complained of a mild, frontal headache, spoke slowly, and generally stared straight ahead. He was cooperative and complained of being frightened because of his inability to recover his memory. He claimed that he did not know his full name, where he was, nor the time or year. He demonstrated some right-left confusion, inability to name common objects, didn't know what a book was (Question: "What is meant by 'You can't tell a book by its cover?'") or what a president is. Short-term and recent memory tested as adequate. Social judgment through hypothetical questioning was poor.

Clinical course: The patient was hospitalized for 7 days, treated with milieu therapy and group therapy, and progressively regained his memory. He received no psychoactive medications. He was seen and cleared for duty by the neurologist.

Discharge diagnosis: Psychoneurotic dissociative reaction, acute, severe. Predisposition: moderate, hysterical personality features.

Disposition: Returned to duty.

Source: Narrative Summary, 935th Psychiatric Detachment/93rd Evacuation Hospital.

The following case is even more complex regarding pathogenesis, diagnosis, and treatment.

CASE 6-8: Treatment-Unresponsive Rifleman With Headache and Auditory Hallucinations

Identifying information: PFC Mike was a 20-year-old rifleman with 14 months service in the Army and 9 months in Vietnam who was hospitalized at the 935th Psychiatric Detachment/93rd Evacuation Hospital.

History of present illness: He was admitted to the brigade clearing station for what was eventually labeled combat exhaustion [the record did not include circumstantial substantiation]. His complaints at that time were of hearing “screeching, shrieking noises” as well as hallucinated voices warning him that people around him were his enemies. He also reported “shooting headaches” and a sleep disturbance. He was held at the clearing station for 2 weeks and treated with Thorazine but without significant improvement. He was then transferred to the 935th KO unit.

Past history: His record only noted that “auditory phenomena have been present for at least 3 years and antedated his induction into the Army.”

Examination: When seen he complained bitterly about his auditory symptoms and expressed intense anger that no one had found the cause and treated it. Besides noting that he was anxious and intense, his mental status examination did not reveal a disorder of his thinking or mood. Psychological testing revealed extensive conflict about aggressive impulses.

Clinical course: The examining psychiatrist wrote, “he is clinically non-psychotic, and I suspect his symptoms are primarily hysterical . . . I can’t be sure that he doesn’t have an underlying thought disorder.” He was prescribed a “diagnostic-therapeutic trial of Stelazine” and returned to his combat unit. Five days later he was again referred to the 935th for persistence of his auditory hallucinations and inability to sleep. When examined, he was calmer, but otherwise he appeared as before. He was again hospitalized and received more Stelazine and analgesics. He participated passively in ward work, recreational, and group therapy programs. His auditory complaints

disappeared by the second day, but the complaints about headaches persisted. On his eighth hospital day he was told that his headaches would have to be “lived with” and that he would be returning to duty. Soon thereafter he began to complain of his original set of symptoms. Nonetheless he was returned to his unit.

Discharge diagnosis: Psychoneurotic reaction, moderate impairment.

Disposition: Return to duty; continue Stelazine and Valium, along with analgesics for headaches. His unit was told that he was fully responsible for his behavior. It was also recommended that he be reassigned to a noncombat unit. He was given an appointment at the 935th KO Detachment in 3 weeks.

Source: Narrative Summary, 935th Psychiatric Detachment/93rd Evacuation Hospital.

See also Bloch’s case #4 in Appendix 12, “Some Interesting Reaction Types Encountered in a War Zone.”

US Marine Corps/Navy Experience in Vietnam

Robert E Strange, a Navy psychiatrist, provided etiologic information regarding combat stress reaction cases evacuated off the coast to the USS *Repose* between mid-February and December 1966. Fifteen percent of psychiatric admissions (raw numbers were not provided by the authors), representing both Navy and Marine personnel, were designated as “classic” combat fatigue (ie, “situational reaction to combat”). These were individuals who had typically been in Vietnam for 6 or more months, sustained “lengthy and harrowing” combat experiences, and, although being junior noncommissioned officers, had shouldered considerable responsibility, such as that of squad leader or corpsman. Their military records were excellent, and they showed healthy pre-Vietnam social histories. Of these cases, following physiological restoration, limited psychopharmacological support, and “supportive-directive” psychotherapy, 78% were returned to duty function, usually with less than 2 weeks of treatment.

In contrast, approximately a quarter of psychiatric evacuations to the ship were also admitted following combat exposure and exhibited similar symptoms of anxiety or depression with psychophysiological manifestations. However, these individuals were ultimately

loosely referred to as “pseudocombat fatigue” because they primarily had personality disorders (or in some instances, psychoneurotic disorders). They were more likely to have background characteristics of impulsivity, poor stress tolerance, tenuous emotional control, and histories of previous psychiatric contacts and poor adjustment. According to Strange, they showed inadequate motivation and poor identification with their military group. Whereas they initially responded to the same treatment as the combat fatigue cases, their symptoms recurred when they were confronted with the prospect of returning to duty in the combat environment (“the crucial test”). Although 50% of the pseudocombat fatigue cases were nonetheless returned to duty, some required rehospitalization and evacuation out of the theater. Several cases of “combat neurosis” were also described. These presented similarly to the “classic” combat fatigue and the pseudocombat fatigue cases. They were otherwise competent individuals who had chronic premorbid but subclinical neurotic symptoms, such as patterns of compulsivity, and whose symptoms were exacerbated by combat.^{48,97}

Special Problems Among Combat-Exposed Troops in Vietnam

Negative Effects From the 1-Year, Individual, Troop Replacement System

As previously noted, maintenance of unit cohesion has been found to be a critical variable in protecting soldiers against combat-generated psychiatric disabilities because of the vitally interdependent relationships required in a successful combat unit. Nevertheless military planners implemented a random, individualized, troop replacement system throughout the war, perhaps assuming that staggering replacements would be less disruptive to mission accomplishment than unit replacements.⁶⁴ They also limited tours of duty in Vietnam to 12 months (US Marine Corps was 13 months), and most soldiers served only one tour. Although the 1-year tour was initially felt to contribute to stress-mitigation, over time it resulted in excessive personnel turbulence and appeared to critically interfere with combat unit morale.⁸⁷ Furthermore, as discussed in Chapter 2, as the war dragged on the Army of necessity had to increasingly rely on relatively inexperienced officers and noncommissioned officers, young draftees, and volunteers.⁹⁸ The impact of this system on the performance and mental health of the troops in Vietnam

was never systematically studied by the Army, but its more general negative effects on individual soldiers was often noted by mental health personnel (see Appendix 8, Byrdy’s account as division psychiatrist during the first year of the war with the 1st Cavalry Division).

Douglas R Bey, the 1st ID division psychiatrist (1969–1970), explored the question of impaired group bonding when individual soldiers, especially soldiers new to Vietnam, joined already functioning combat units. Bey described how the unit’s members ritualistically hazed the initiate while encouraging him to diminish his ties to home, embrace the group, and, especially, to adopt the group’s psychological defenses of denial and counterphobic bravado. He indicated that this was a precarious process, and, for some, obstacles such as a new member’s social, cultural or language handicap threatened the group’s homeostasis and provoked their harsh and even violent reactions toward him, which in turn resulted in higher psychiatric referrals. Bey and his team developed a program in which they sought to help unit commanders reduce the stress and foster the unit’s integrity and continued effectiveness through empathy for the initiate, admission of more than one replacement at a time, improved orientation, and assigning him a sponsor.⁹⁹ However, in general no measures of the effects of this program were available.

Short-Timer’s Syndrome

The so-called short-timer’s syndrome—a low-grade form of emotional and behavior disability exhibited by combat soldiers as they approached the date they were to rotate back to the United States (date expected return overseas or DEROS)—was regularly observed by commanders and treated at all medical care levels. Symptoms especially included reduced combat efficiency; preoccupation with fears about being killed; sullen, irritable, or withdrawn behavior; and opposition to further combat participation. It was also common for noncombat troops to experience a version of this upon nearing their DEROS,⁴⁷ evidently because of absence of clearly defined rear areas and a lack of sense of safety. One must remember that for the combat soldier who was getting “short,” the individual rotation policy guaranteed that his inevitable anxiety about leaving Vietnam alive and in one piece would be greatly fueled by his awareness that, simply based on longevity, he was literally the last man. He had witnessed the gradual disappearance of the cohort of soldiers he joined when

he arrived by their having become casualties, through sickness, or as a consequence of their DEROS. The reality that many members of his unit left unscathed may not have modulated his tendency to envision that when his turn arose, it might come in the more adverse form (ie, killed or wounded).

The emergence of this type of psychological disability was also consistent with professional observations regarding the psychological defenses employed by combat troops to keep their fears and anxieties under control. Because, as observed in Bourne's studies of combat stress,⁹⁰ soldiers commonly used the mental defense of denial in order to tolerate the high risks of combat, the individual soldier's belief from early in his tour that his odds were favored because of the spread of risk over time and among the combat group would gradually erode because of the steadily diminishing time and numbers. Short-timer's symptoms were only so preventable—recall from Chapter 3 that Jones (25th Infantry Division) observed that commanders who established a policy of exempting soldiers from combat exposure within a month of their DEROS found these symptoms arose even sooner among the other troops. Similarly, Byrde (1st Cavalry Division) reported that such a policy resulted in so much bitterness within the unit that the concession had to be rescinded. (Short-timer's syndrome will be explored in general in Chapter 8.)

Evidently, low-grade short-timer's pathology was so common in the combat units and relatively manageable that most of the deployed psychiatrists felt it unnecessary to publish case examples. However, for some individuals approaching their DEROS could awaken more serious psychosocial conflicts pertaining both to Vietnam and to what was waiting in the United States. The following case record from the 93rd Evacuation Hospital/935th KO Detachment serves as illustration:

CASE 6-9: Acute Stress Reaction in an Infantryman Within 2 Weeks of Going Home

Identifying information: Specialist 4th Class (SP4) November is a 20-year-old, single, white infantryman with over 2 years in the Army and 11 1/2 months in Vietnam (ie, within 2 weeks of DEROS).

History of present illness: He was taken to his battalion aid station at 2000 hours after he jumped off his track

and ran into the jungle muttering something about getting "Charlie" (Viet Cong) because Charlie had killed several of his buddies. His unit was setting up a night perimeter at the time. He had had 5 or 6 beers before the episode. Upon being seen at the clearing station, a diagnosis of combat fatigue was made, and he was given Thorazine and restrained. The next day he was transferred to the 93rd Evacuation Hospital.

Examination: Upon arrival at the 935th he was noted to be somewhat withdrawn, staring at the ceiling, and answering questions tersely and in a monotone. After being admitted to the ward, he slept through the night. The morning after admission he was alert, oriented, and without complaint. He was described as a sober, somber, somewhat sad-faced young man with a reticent, though cooperative, manner. He denied a history of psychotic symptoms or those of severe neurosis or suicidal or homicidal intent. He had good immediate and past memory, general fund of information, social judgment; proverbs were interpreted concretely. He acknowledged unresolved feelings about his dead buddies and was hesitant to discuss these, but he noted that it would take time for these feelings to become settled. There was no evidence of severe depression. He reported an earlier episode of "blacking out" subsequent to drinking alcohol several months earlier. He denied past or recent use of drugs, including marijuana. His physical exam was within normal limits.

Past history: SP4 November was one of eight children. His father was permanently hospitalized following an injury when SP4 November was 1 year of age. Shortly thereafter his parents divorced. Following his mother's remarriage, he was raised by a stepfather toward whom he had mixed feelings. His mother died when he was 16, and an older brother committed suicide last year. He denied neurotic symptoms in childhood, though he always had a penchant for solitary activity. He quit school at 16 and joined the Army.

Clinical course: Unremarkable. The clinical record does not indicate that additional medications were prescribed. He was discharged after day 2.

Discharge diagnosis: Adult situational reaction—acute, moderately severe; manifested by dissociative-type symptoms. Stress: alcohol; unresolved feelings about

lost buddies; preparation to leave the war zone.
Predisposition: moderate. Condition at discharge:
recovered.

Disposition: Return to duty. Recommendation:
Consider keeping him in company area until DEROS.

Source: Narrative Summary, 935th Psychiatric
Detachment/93rd Evacuation Hospital.

Chronic Combat Stress Reaction

Overlapping symptomatically with short-timer's syndrome were some soldiers who had previously withstood extensive combat but who became severely disabled in the last couple of months of their tour, apparently consequent to cumulative stress. William L Baker, the division psychiatrist for the 9th Infantry Division, referred to them as the "ten month veteran (syndrome)," and his successor, Robert L Pettera, referred to them as the "Vietnam combat reaction" (he also referred to them as "combat neurosis"). Early in the war Strange and Ransom J Arthur, also a Navy psychiatrist, similarly noted a second incidence peak for combat stress casualties treated aboard the USS *Repose*, a Navy hospital ship. According to them, some Marines who were highly conscientious, if somewhat anxious and "neurotic," developed incapacitating symptoms after approximately 10 to 11 months of combat duty in Vietnam.^{100(p285)}

The following is Baker's description of the "ten month veteran" (syndrome):

Its symptoms are so nearly uniform from one man to another, and different from the classic combat fatigue syndrome, that I feel it is a syndrome produced by the [unique] stress encountered here. The typical case is an infantryman who had been with the division since training in the [United States] and in Vietnam for ten months. His past history indicates good-to-superior duty performance and social adjustment. He had a normal degree of fear and anxiety during most of that time [in Vietnam]. Recently there has been a considerable increase in anxiety, to a degree markedly impairing his ability to function, often in spite of continued motivation. Referral notes from battalion surgeons often indicated that the man repeatedly went in the field

and was non-effective and had to be evacuated because of symptoms. He complains of all the usual "short timer" feelings, in other words, a sense of impending doom. He fears he will "get someone killed" by making a mistake, sleeps poorly, has recurrent bad dreams in which he sees again some specific horror. He has functional anorexia, nausea, and often "dry heaves" or cramps. Some have been evacuated with a diagnosis of appendicitis. Often there is a fear of artillery noise, even outgoing, which seems to be more of a conditioned response than rational fear. The patient is often more distressed by his recurrent dreams than by fear of returning to combat. He says he will return to combat willingly if only he could sleep without "those dreams." Usually the dreams are not a fantasy of what may happen, but are "re-runs" of something that did happen (ie, being splashed with a friend's brains, etc).^{75(p6)}

These cases combined elements of the "old sergeant syndrome" of World War II (described in Chapter 3) and the short-timer's syndrome. Affected individuals seemed to especially illustrate what Richard Rahe later came to describe as a chronic combat reaction. This refers to a state of psychophysiological hypoarousal with attendant psychological depression and withdrawal secondary to continuous exposure to high stress demands. In contrast, the temporarily disabling acute combat reaction would apply to soldiers experiencing an abruptly arising physiological hyperarousal, that is, panic reaction (so-called battle shock¹⁰¹).¹⁰² The following case example is illustrative of the chronic combat stress reaction:

CASE 6-10: Chronic Combat Stress Reaction in a Battle-Hardened Track Commander

Identifying information: SP4 Oscar is a 21-year-old, single, white infantryman with 2 years in the service and 11 months in Vietnam. He was transferred to the 935th Psychiatric Detachment on 1 June after a 3-day stay at his brigade medical clearing station for "combat fatigue," which did not clear with rest and sedation.

History of present illness: Patient has performed well throughout his tour, but over the past 2 months became increasingly preoccupied with and upset by the gore, wounding, and chaos. He has been having nightmares, became emotionally labile, and expressed that he has “had it!” He noted that he had become socially withdrawn in an effort to avoid hearing about killing. He expressed guilt about surviving while many buddies had died. Two weeks prior he was taken off the line and given a job at the base camp.

Examination: SP4 Oscar presented as “tearful, earnest, disheartened, disconsolate, though not despondent young man.” His mood was depressed and his affect was labile. He spoke vehemently, though without pressured speech; his associations were relevant; he was not homicidal or suicidal; there was no evidence of psychosis or intellectual impairment. In addition, his attending psychiatrist included the following observation, apparently suggesting the patient was in a psychologically regressed state, “[He] presents himself as a bit helpless, which I suspect is not typical for him.”)

Past history: The clinical record contained no details regarding his past history. He denied use of drugs or alcohol.

Clinical course: According to the record, “The patient’s reconstitution had begun before he arrived at the 935th.” Once he was at the 935th, he was put to sleep with Thorazine for 20 hours. Subsequently he reported feeling better and wished to return to duty. He was discharged on the second day of hospitalization.

Discharge diagnosis: Adult situational reaction, acute, moderately severe; Stress: chronic battle exposure; severe; Predisposition: none; Impairment: none; his emotional lability, fatigue, and guilty ruminations were in remission.

Disposition: Returned to duty (noncombat).

Source: Narrative Summary, 935th Psychiatric Detachment/93rd Evacuation Hospital.

Behavioral and Psychosomatic Symptoms Among Combat Troops

The psychiatric literature from Vietnam was mostly silent on soldiers exhibiting specific maladaptive behaviors associated with combat risk and exposure, that is, malingering, desertion, absent without leave (AWOL) in the field to avoid combat duty, combat refusal, and neglect of healthcare, weapons, or equipment. Jones,¹⁰³ who served very early, and Bey, who served midwar,¹⁰⁴ both commented that few self-inflicted wound cases were seen. However, according to Raymond M Scurfield, an Army social work officer, Blank (1966–1967) had told him about a soldier who shot himself in the chest with his rifle to manipulate a transfer from Vietnam. Also, Scurfield reported that when he was assigned to the 98th KO Detachment (1968–1969) they saw several self-inflicted wound cases.¹⁰⁵ Larry E Alessi, who served with the 23rd ID during the drawdown phase, mentioned that combat refusal had become a problem (Appendix 9), and Harry C Holloway, a research psychiatrist, reported that early in the war, units with poor morale were lax in malaria discipline, with some soldiers indicating that they purposefully exposed themselves to mosquito bites in an attempt to get relief from the field.¹⁰⁶ Soldiers with less conspicuous behavioral expressions of resistance to combat exposure (in the language from earlier wars, the “goldbricks” and “stragglers,”⁷ and in Vietnam, “shammers”), as well as those with factitious medical/psychiatric disorders or exaggerated psychosomatic problems who hoped for exemption from combat, that is, for “secondary gain,” also got little explicit acknowledgment by the reporting Army psychiatrists. Undoubtedly such behaviors were widespread, and if such soldiers received psychiatric attention they were most likely labeled as either a character and behavior disorder or an adjustment disorder. More likely is that they were treated symptomatically by the primary care physicians or other medical specialties and not referred.

Regarding exaggerating physical symptoms to avoid duty, especially combat duty, Allerton, who did not serve in Vietnam, provided the following statement in his 1969 overview, “[Because] there is no area within the country that is without danger . . . there is little merit in developing secondary gain type symptoms which might consciously or unconsciously be utilized to extricate oneself from a dangerous situation.”^{6(p16)} However, this may have been a naïve assumption. SP5 Paul A Bender, an enlisted social work/psychology

technician, indicated that “iatrogenically aggravated,” functional psychosomatic symptoms were among the most intractable cases seen in the 11th Infantry Brigade in early 1968,¹⁰⁷ and Carden and Schramel, US Air Force psychiatrists stationed at Clark Air Force Base in the Philippines who treated soldiers evacuated from Vietnam, felt that even during the first year of the war, the war’s unpopularity contributed substantially to secondary gain as motivator for certain types of psychiatric disability in Vietnam.¹⁰⁸ (See Chapter 8 for more on the findings of Carden and Schramel.)

As for soldiers presenting with psychophysiological symptoms and conditions, it seems likely that large numbers of unrecognized combat stress cases were represented in this population. In general, the psychiatrists who produced reports from Vietnam said little about this group. One exception is Blank (3rd Field Hospital), who reported early in the war that 20% of his inpatients were “psychosomatic” cases, and that he suspected there were many additional cases being treated by other physicians. However, he did not explicitly tie these cases to combat stress. Also early, Byrde (1st Cavalry Division) reported that 4.8% of his referrals received as their primary diagnosis that of “psychophysiological reaction,” but he did not link their symptoms to combat stress either. Late in the war, Alessi (23rd Infantry Division) was very explicit that psychophysiological symptoms had become the most common combat-generated psychiatric reaction, and he advocated that the battalion surgeons prescribe the neuroleptic tranquilizer Mellaril for these soldiers. Intriguingly, in the follow up to his study of outpatient psychotropic drug prescription patterns in Vietnam (with Dattel),⁹⁵ Johnson reported that Compazine, also a phenothiazine neuroleptic, which was mostly prescribed for gastrointestinal irritability, accounted for 45% of all psychotropic prescriptions written by the primary care physicians in Vietnam. Furthermore, it was his assumption that most of these cases were generated by combat and related stress.⁸¹

The subject of alcohol and drug use by combat troops will be addressed in Chapter 9. Overall, there are ample data to indicate that use, abuse, and dependency were widespread problems with respect to alcohol throughout the war, marijuana beginning early in the war, and for heroin from mid-1970 until combat troops were withdrawn in 1972. However, in general there are not sufficient data available to indicate greater use of drugs or alcohol among combat troops or that the use

of these substances was an additional risk factor in the pathogenesis of combat-related conditions. On the other hand, a number of commentators posited that both marijuana and later heroin were commonly used in the field by troops to calm down after combat engagements.

Otherwise, there were undoubtedly many psychiatrically disabled soldiers with complex etiologies that included at least the prospect of combat risks or a history of combat exposure but without evidence of acute combat stress, or certainly not combat exhaustion, *per se*. As such they defied neat categorization of combat versus noncombat stress. Probably it should be suspected that any significant psychiatric symptom or problematic behavior in the theater might be etiologically linked to combat stress or an experience of combat traumatization (as suggested by Bruce Boman, an Australian psychiatrist⁸). The following case example, extracted from a report from the 1st Infantry Division Mental Health Consultation Service (April 1969–April 1970), involved a corpsman who was facing charges for combat refusal. It demonstrates how SP5 Walter E Smith, an enlisted social work/psychology technician, provided effective therapeutic counseling to the patient for his underlying traumatic experiences and effective consultation to his unit cadre and battalion surgeon.^{109(p365)}

CASE 6-11: Field Medic Accused of Combat Refusal

Identifying information: SP4 Papa is a 19-year-old Puerto Rican combat medic who was seen by the psychiatric technician after referral from his battalion surgeon in anticipation of his being court-martialed for combat refusal.

History of present illness: The patient had been experiencing increasing internal and external stress from combat exposure for some time. Two months prior to referral he had been wounded during an ambush in which his company commander and several friends were wounded or killed. During the confusion following a retreat, several wounded men were apparently left in the field. The patient had returned under fire to aid them but was unable to save the life of a friend. After being seriously wounded, he attempted to carry the company commander (whom he later said he respected and admired “like a father”) to safety, but he was unable because of his own small

stature and his wound. When ordered to the rear, he became hysterical and was “dusted off” (evacuated by helicopter) prior to men whom he considered to be more severely wounded. In the clearing station the patient became depressed and self-critical. When he was returned to his unit several weeks later, he refused to go to the field because he felt he had proven he was a failure as a medic and did not want to cause further harm to his platoon because of his inadequacy. The platoon was later ambushed and, because of his refusal to participate, the patient further blamed himself for their casualties. All this was compounded because the patient’s immediate superior was an “old Army” Mexican American NCO [noncommissioned officer] who reacted to the patient’s depression and combat refusal by insisting that he “be a man” or else be punished for cowardice.

Past history: None provided.

Examination: During the initial interview and in consultations with his superiors and peers, it became apparent that SP4 Papa had an excellent record after 7 months in the field and was admired by his company for his capabilities and dedication as a combat medic. The referring battalion surgeon noted that the patient appeared to be under stress, but he failed to fully appreciate the extent of the problem due to a breakdown in communication with him.

Clinical course: The social work/psychology technician allowed the patient to talk about his situation and his feelings, and a trusting relationship was developed. Counseling was directed toward helping him to be less critical of himself in order to rebuild his self-esteem and confidence, while permitting him to mourn the loss of his friends. In addition, the technician met with the patient’s NCOIC [noncommissioned officer in charge] and the battalion surgeon to facilitate their understanding of his dynamics, especially the “homeostatic necessity” [Author: meaning it served to preserve self-esteem rather than represented an adaptive failure] for his seemingly “cowardly” behavior.

Discharge diagnosis: None provided.

Disposition: As a result of these interventions, the patient regained his previous level of functioning and completed his tour of duty in the field.

Source: Adapted with permission from Bey DR, Smith WE. Mental health technicians in Vietnam. *Bull Menninger Clin.* 1970;34(6):365–366.

The next case example demonstrates the prophylactic recommendation of noncombat assignment for a combat soldier with demonstrably low intelligence and education.

CASE 6-12: Depressed Machine Gunner With Low Self-Confidence

Identifying information: PFC Quebec is a 19-year-old, white machine gunner with 1 year in the Army and 3 months in Vietnam. He was referred to the 935th Psychiatric Detachment for evaluation and treatment for anxiety and depression.

History of present illness: He reports he always “messes up” and is fearful that he would mess up in his machine gunner job if the column were to be attacked. He intimated to a friend that he might commit suicide as a solution (allegedly the friend removed the firing pin from his weapon after he tried to shoot himself). The division psychiatrist feels he is fit for duty, but the commanding officer and the battalion surgeon feel he is not.

Past history: PFC Quebec is the fourth of five children. He left school after the 4th grade and worked as a cow-puncher. He later got a 6th grade equivalency education. He was denied entry into the Army on three previous tries. He completed truck-driving training as well as became an expert machine gunner.

Examination: His IQ [intelligence quotient] measured at 86. He is not psychotic but does present with low self-esteem secondary to low education and intelligence.

Clinical course: Unremarkable over a 2-day hospital stay.

Diagnosis: Chronic, mild depression.

Disposition: Returned to duty; recommended transfer to a combat support unit.

Source: Narrative Summary, the 935th Psychiatric Detachment/93rd Evacuation Hospital.

US Army Combat Stress Research in Vietnam

The historical debate between external stress versus individual predisposition as the best explanation for combat breakdown took a turn toward the latter as a consequence of a pair of studies conducted in Vietnam in early 1966 by the Neuropsychiatry Division of WRAIR, which were directed by Rioch and conducted in the field by Bourne and his associates. Over a 3-week period the investigators measured physiological stress levels and emotional states in members of an elite combat unit (Special Forces “A” team) under threat of attack. They repeated this approach with members of a noncombat unit (helicopter ambulance medics) who were intermittently subjected to great combat risks. The research protocol involved collecting 24-hour urines to measure steroid excretion levels (urinary 17-hydroxycorticosteroid [17-OHCS]) and analysis of self-reports of emotional states (using the daily form of the Multiple Affect Adjective Check-List [D-MAACL]).¹¹⁰

The Special Forces team (N = 11) was camped in the central highlands in territory controlled by the Viet Cong during a phase when an enemy attack was predicted. Over the course of the study the authors found no significant daily increases in steroid excretion levels except for the two officers. However, on the day of the anticipated attack, the commanding officer and the radio operator showed significant elevations. These results suggested that stress levels increased for those who were more knowledgeable of the real risks or were among those in positions of greater responsibility.¹¹¹ Administrations of the D-MAACL were obtained during the same time frame and were compared for anxiety, depression, and hostility levels. Scores and participant observations corroborated that hostility was the dominant affect expressed.¹¹²

Regarding the helicopter ambulance medics (N = 6), steroid excretion levels showed little variation from the overall mean and did not correlate to objective measurement of danger. In fact, on the basis of weight alone, the chronic mean level for each subject was lower than predicted.¹¹³ However, anxiety scale scores from the D-MAACL (high, middle, and low) were significantly correlated with type of daily activity (combat mission, work, or day off). Interviews revealed that subjects used

an extensive range of psychological defenses to perceive risk situations as less dangerous, thus enhancing feelings of omnipotence and invulnerability and allowing a high level of adaptability to the unit mission.¹¹⁴

Bourne interpreted the overall results as:

Among psychological defenses utilized by fighting men are religious faith, a statistical conclusion that the chances of being killed or injured on any one day are small, inordinate faith in one's own ability to stay alive, and a restructuring of reality to avoid facing the danger. In the process of ignoring danger . . . there can be a generalized suppression of affective arousal as reflected by normal, or even below normal, urinary 17-OHCS levels.^{115(p10)}

Glass added that these results validate clinical impressions that “an event is only stressful for the individual when he perceives it as such,”^{57(pccviii)} and that the individual's characteristic defenses serve to mitigate the stress (ie, his individual psychological style, especially denial, suppression, reliance on others, religious faith, and compulsive activities).⁵⁷

However, it is uncertain how much to generalize to the average soldier from studies of combat adaptation among members of elite units. For example, in their study of Special Forces veterans of Vietnam (over 10 years after service in Vietnam), Neller et al found them to be somewhat immunized from combat stress, at least while in the theater. This was presumed to be the product of their being volunteers and several years older than the average soldier, their repeated pledges of mutual support, and the extensive specialized training they received, especially in the use of guerrilla warfare tactics, which afforded them a resistance to the tactics guerrilla forces use to try to psychologically separate troops from their base of support.^{63,116}

The Role of Demoralization and Psychological Conflict in Combat Reactions: Postwar Considerations

Disabling Psychiatric Conditions as a Function of Demoralization

In the aftermath of the Vietnam War, references to combat-risk avoidance as a primary motivation for combat reactions still appeared in the military psychiatry literature, even if not implying the moral judgments from earlier times. Harry R Kormos, a Navy psychiatrist,

provided a thorough review of combat-related psychiatric casualties in American wars from World War I through Vietnam, which ranged from psychotic disorganization to drug abuse and assassination of superiors, and posited that “refusal to fight” was a central dynamic in these conditions.^{16(p11)} Scientific support for this model from the Vietnam theater came from Bourne, who summarized his own findings and those of others: “A slowly shifting emphasis, culminating in the Vietnam experience, has led to a conceptualization of the psychiatric casualty as an adaptive failure of a basically temporary nature rather than a disease entity.”^{9(p229)} Furthermore, according to Bourne, although the majority of hospitalized soldier-patients in Vietnam were categorized as character and behavior disorders, the actual presenting symptoms, which in earlier wars could have taken the form of a hysterical paralysis or a self-inflicted wound, have been socially or culturally shaped and mask the critical issue—that the soldier has ceased to cope and function in the combat environment, with their “manipulative” goals being to pursue a socially permissible means for opting out of combat risk. He concluded that healthy men only succumb to combat stress under exceptional circumstances, and that psychiatric attrition is mostly limited to those with predeployment, including subclinical, personality susceptibility, that is, deficits⁹ (see next section).

Corroboration also came from Noy, who drew upon later Israeli military experience. He noted the correlation between combat intensity and all forms of “exits” from the battlefield, that is, not only combat reactions and other psychiatric conditions, but also disciplinary exits and medical exits for disease and nonbattle injury. According to Noy,

Combat reaction [is] one of a family of stress syndromes with various expressions, including psychiatric, medical and disciplinary . . . [which] can be understood in terms of a clinical entity, a social entity, and a communication of “I can’t take it any more.”^{117(p84)}

Jones basically agreed but argued for combat avoidance as a secondary motivation. Still, he reiterated the traditional view of military psychiatrists that, when a soldier becomes a combat reaction type of casualty and is not managed with the forward treatment doctrine, there is a significant risk that his condition will become intractable because it affords him an honorable means

for escaping additional combat risk while salvaging his self-esteem and warding off guilt.⁵ However, there were no studies conducted during the war to confirm this assumption.

Regrettably, also not measured in Vietnam was the effect of sagging overall morale in the theater over time and consequent impairment of combat effectiveness and psychological resilience and durability of combat-exposed troops. As senior Army social psychologist FJ Manning compellingly argued: whereas in earlier wars “commitment and cohesion” within the small combat unit were found to be crucial in mitigating individual combat stress (a finding that linked with the historic observation that “ideology [only] serves to get soldiers into battle”^{40(p7)}), there is ample evidence to indicate that this was contradicted in Vietnam where the lack of widespread agreement on the necessity for, and the value of, the war effort in America severely undermined the morale and *esprit de corps* of US forces.⁴⁰

Disabling Psychiatric Conditions From Psychological Disturbances Within the Individual Soldier

Despite advances in the psychoanalytic structural model and other, more general, enhancements in so-called ego psychology, the literature from the Vietnam War era contained little to further the understanding of the contributions of *intrapsychic*, or mental/emotional, conflicts in the pathogenesis of combat stress disorders among individual soldiers (a model advocated by Bloch with the 935th Psychiatric Detachment). However, findings of three psychoanalysts (mental health professionals with additional extensive training in psychological infrastructure) who treated veterans from Vietnam permit, by extrapolation, development of a model of pathogenesis for some combat reactions that arose there. Generalizability of their findings and conclusions to soldiers affected in the theater is, of course, limited because the subjects were veterans and because they were patients. There were no non-symptomatic controls, and undoubtedly patient presentations were affected by the passage of time and by shifts in their status (active service to civilian) and context (Vietnam to stateside).

Effects of the Interaction of Predisposing Psychological Disturbance and Combat Events

Army psychiatrists PM Balson and CR Dempster described results from their evaluation of 15 combat

veterans using hypnosis. They interpreted their findings as arguing for a psychodynamic etiology of “combat neurosis,” representing the conjunction of a “chance traumatic reality stress” with an “internal affectual experience.” For the soldier-patient, the symptom selection may serve to symbolically express his “disordered self-perception.” In other words, the authors believed they verified a theory of internal conflict and “compromise formation” (as advocated by Erikson), at least among some casualties, in which a combat trauma causes a strong regressive response that is qualitatively specific for that soldier.¹¹⁸

Combat-Associated Guilt as a Principle Source of Psychologically Disturbance

Corroborating and extending their conclusions were the observations of Harvey J Schwartz. Schwartz reported on his experience conducting analytic psychotherapy with Vietnam veterans—an approach that permitted a deeper appreciation of the “personal meaning” of the veteran’s combat experience. In particular Schwartz studied his patients’ verbal associations, dreams, and transference reactions to him (as subjectively derived distortions), with a primary focus on the role of unconscious guilt (a chief element in intrapsychic conflict) in the pathogenesis of their combat-centered adjustment difficulties. His rich, nuanced description of his therapeutic process with Patient B serves as a model of care that took into account his unconscious motives and defenses, effectively restoring a psychologically wounded soldier-veteran. (“The patient served in Vietnam in continuous combat for 10 months. He was the point man for his unit which brought him into intimate contact with the most violent and dangerous aspects of guerrilla warfare. Death and mutilation were an everyday encounter, and most of his friends were either maimed or killed.”^{119(p61)}) Notably, there is no reference to the patient developing symptoms in the theater, and his symptoms as a veteran proved primarily to be grounded in his pre-Vietnam personality organization and in his reported excessive combat aggression in the field (he killed a defenseless civilian).

With regard to the effects of predisposition, Schwartz argued for a common sense, “bifocal” approach for understanding posttraumatic psychological disturbances and disability:

Regression, the inevitable response to massive stress, can, in and of itself, lead to altered [mental]

functioning. To claim that all regression derives from [predeployment] predisposition is . . . to misunderstand the organism as a physiological entity whose primary motive is survival. On the other hand, to state that [soldiers’] emotional conflicts begin only at the moment of trauma and that they bring none of their past distortions to that event is . . . to be naïve about psychological functioning. Stressful events can only be perceived through the veil of [ones past].^{120(ppxvi)}

The Potential for Widespread Guilt Among Troops Fighting in Vietnam

Nadelson, a psychiatrist who spent much of his professional career evaluating and treating veterans at the Boston DVA Hospital, ultimately synthesized his impressions in his book, *Trained to Kill: Soldiers at War*¹²¹ (elaborated with verbatim interviews with Vietnam veterans in a companion publication, *Attachment to Killing*¹²²). In contrast to the hypnotherapeutic methodology of Balson and Dempster,¹¹⁸ or Schwartz’s utilization of psychoanalytic theory in the treatment of individual cases,¹¹⁹ Nadelson’s approach^{121,122} centered on interpreting vignettes from veterans of World War II, Korea, and especially Vietnam, through the various lenses of the history of war, philosophy, social anthropology, ethology, neurobiology, social psychology (both macro and micro), and biopsychodynamic developmental theory.

According to Nadelson, a fundamental precombat susceptibility to psychological disorder in troops arises from the innate characteristics and anxieties within all young males. The effect is that to a certain degree they welcome participation in the lethal, winner-take-all experience of war as the quick and sure path to establish a confident masculinity (“The myth of maleness . . . ”^{121(p3)}). Not only does combat permit the expression of such masculine traits as daring, impetuosity, and male-bonding, but since sanctioned killing in the service of the nation’s protection is honorable (and “a male duty”^{121(p42)}), the young soldier may be forced, as well as permitted, by the immediacy of combat to fully exercise the primal male drive to possess and dominate (with killing as its highest form), while at the same time “rejecting all that is civilian and soft.”^{121(p24)} However, it is unmistakably a harsh test. (“Men’s self-esteem has been strongly shaped by evolutionary and cultural pressures toward use of counterforce rather than surrender. . . . Failing to

do so, even if the possibility of successful response to overwhelming force to save oneself or a comrade is slim or nonexistent, is psychologically devastating, and the memory is haunting.”^{121(p88)} At stake is the misery of being a failed male. (“You’re pussy.”^{121(p24)})

However, this can be a slippery slope: killing can become addictive. According to Nadelson, “Killing the man who would kill you while escaping injury is electrifying (“a hyperaroused, excited emotional state”^{121(p79)}). Soldiers in contact with the enemy become enthralled. They risk death focusing only on destroying the enemy. The reflex to defend against mortal harm results in lust and freedom—no thought, only action.”^{121(p6)} He also, like other psychiatric observers in Vietnam, commented on the potential for the sexualization of killing. (“Men at war experience intense excitement—orgasm pushed up a notch, an automatic weapon on ‘rock and roll.’ In its momentum toward absolute force, war can engage some of its participants in savage amusement—which defines the perverse. . . .”^{121(p70)})

Given these features, it is not a stretch to appreciate how the combat-required killing can spiral into unconstrained use of force and atrocity (with societally unsanctioned killing referred to as “murder”). According to Nadelson, “[With respect to Vietnam] the danger of being overrun—the enforced passivity before engagement—agitates men beyond comparison and demands assertion of mastery. Such feelings, especially if leadership is poor or weak, can move the susceptible to atrocity. Once the killing started [in Vietnam], soldiers could not break cohesion with friends—they killed together. Love . . . can also pull soldiers into evil.”^{122(p60)}

As discussed in Chapters 1 and 2, the Vietnam War brought with it several novel features that appear to have greatly magnified the potential for these types of conflicts within the soldier: (1) the great expansion in firepower under the control of the individual soldier compared to his earlier counterparts; (2) the enemy’s terrorist/guerrilla tactics encouraged equivalent, more brutal responses from US troops; (3) the failed US strategy of enemy attrition employed there (“The Vietnam War stretched the envelope of ‘just’ rules designed to control the actions of soldiers. . . . The war’s incoherence affected the men on the ground, lessened the claim of rules and standards, and, in that, further demeaned them. Killing—the body counts—became command’s purpose because they had no other, and for many ordinary soldiers, killing became their purpose,

too.”^{121(p59)}); and (4) effects from the reversal of the American public’s approval for the war. According to Nadelson, “[T]he soldier’s real work is killing. The soldier’s [societally granted] privilege to kill is unlike anything most other individuals have ever experienced, and the soldier who kills is permanently changed, fixed to the death he has made.”^{121(p38)} When the “privilege” was revoked by a disheartened America (“There were none of those customary and necessary ‘expiatory rituals’ . . .”^{121(p52)}), combat troops were left holding the (moral) bag.

As for the clinical effects of this rich combination of psychologically disturbing factors, it appears that it is Nadelson’s legacy to serve as an eloquent witness to what all this did to the more susceptible troops in Vietnam (and it would seem to be naïve to assume that this only pertained to veterans no longer in the theater, see Case 6-1, PFC Foxtrot; Case 6-2, PFC Golf; and Case 6-3, PFC Hotel.). The following are selected examples from Nadelson:

- For many of the boys who fought in Vietnam, combat lifted a corner of the expected universe. They experienced a world in war moved only by uncompromising necessities, where life and death were regulated by immediacy (or accident), stripped of the rules and conventions. Some boys achieved a precocious manhood, conferred on them by the intensity of the experience, the power of their brotherhood and weapons. Many felt strong, exultant, and empowered after survival in Vietnam in the fellowship of their comrades.^{121(p21)}
- When the brain reward systems are firing, everything feels right, and there is no need for an external moral sanction; the good feeling speaks only of the rightness of the moment. With your brain buzzed, the feeling of flow, of one’s control and certainty amid the unpredictable, sometimes carries a person with it [to excess]. . . .^{121(p115)}
- Combat veterans said of themselves that in Vietnam as adolescents they were “lords of death,” “kings,” “gods.”^{121(p59)}
- For many, a constant dark shadow of guilt about the satisfaction of and charge in killing in successful counterforce lingers.^{121(p92)}
- For some soldiers, the nature of the war in Vietnam and, they fear, their own nature, carried them beyond defined civilized limits, and they cannot find those limits within themselves again.^{121(p48)}

- Some still are deeply troubled by the thought that [perceived excess aggression] rose out of a profound defect in their own character. Many register deepest sadness about what they became . . . and also speak with great clarity about what the availability of force did to them.^{121(p59)}

In conclusion, although Nadelson's review and analysis is rich and liberally illustrated with clinical vignettes, unfortunately he did not provide detail regarding his methodology or data. Nonetheless, it is a compelling essay by a distinguished psychiatrist and psychoanalyst on the wrenching effects of war based on his innumerable clinical encounters with combat veteran-patients spanning two decades. In particular his findings also appear to coincide with some of the clinical examples and other professional observation from the Vietnam theater. If not serving hypothesis testing, certainly his observations and conclusions regarding a generally taboo subject, the sometimes damaging (to self or others) pleasure soldiers often derive from participation in combat, deserves more attention.

USMC/Navy Studies of Combat Stress Treatment and Combat Effectiveness

USMC/Navy Experience at Khe Sanh

As has been previously noted, this work does not attempt a full review of the psychiatric experience of the Marines and Navy personnel deployed in Vietnam. However, a unique opportunity for the study of combat stress in Vietnam among ground troops pinned down by enemy fire arose during the 76-day siege of the 5,500 Marines and Naval personnel located on the Marine base at Khe Sanh in early 1968. Lieutenant Commander Stephen W Edmondson, a Navy psychiatrist, and Lieutenant (Junior Grade) Donald J Platner, a Navy psychologist (both of whom were attached to the 3rd Marine Division), reported that the percent of personnel who received psychiatric evacuation to either the 3rd Medical Battalion at Phu Bai or to the hospital ship, *USS Repose*, during the two-and-a-half month siege (1.3% [67 cases]) did not represent an increase over the percent who received psychiatric evacuation during the relatively quiet month before it began (26 cases). They credited high morale and confidence among the Khe Sanh defenders and the excellent field treatment provided by battalion surgeons and corpsmen ("sedation and tranquilization in a relatively safe place"). However,

they also acknowledged the hazards associated with air transport off of the base, suggesting that this may have discouraged evacuations and distorted the metric. Perhaps more important, "situational reactions," mostly of the anxious type, that is, combat stress reactions, went from 4% of evacuees (one case) before the siege to 34% (23 cases) during the siege. Also, as a sidebar, because of special stresses, Navy corpsmen were overrepresented in the psychiatric evacuees during the siege (10 cases). (Strange also found corpsmen overrepresented in Marine combat fatigue cases earlier in the war.⁹⁷) Finally, 60% of all evacuated psychiatric cases from the base (40) were ultimately returned to duty in the theater.⁶²

Correlation Between Background Features and Combat Performance

On the side of prevention, background qualities contributing to enhanced combat effectiveness (and which presumably serve to buffer against combat breakdown) were studied among Marines by Jack L Mahan and George A Clum. They examined the records of 831 first-enlistment Marines who served in Vietnam early in the war (1964–1965) and sought to correlate their field supervisor's rating of their combat performance in Vietnam (a single rating on a 7-point scale) with pre-Vietnam predictor variables. Overall the group achieved a mean rating of 4.99. One-third had ratings of either 6 or 7, and only 3% had ratings of 1 or 2. Of the predictor variables, 40 (of 70) were significantly correlated with combat effectiveness. These described the effective combat Marine as older, better educated, and white, with more siblings and fewer arrests. In the recruit processing, he had measurably higher intelligence and aptitude, especially in the areas of general information, mechanical aptitude, and arithmetic reasoning. In recruit training, he showed good drill instructor ratings. Higher second year ratings for performance, personal relations, and overall adjustment were also predictive of later combat effectiveness.¹²³ Although these findings make intuitive sense, it is regrettable that they were only collected very early in the war. It can be assumed that the number of Marines who brought these qualities into the theater would have decreased as the war prolonged because of the 13-month tour limits and the rapid turnover of personnel (see section on excessive combat aggression).

Additional observations regarding Marines and combat stress-related psychiatric conditions are found

in the summaries of the report by Ted D Kilpatrick, who was assigned to the 3rd Marine Division in 1967 (Chapter 3), and the reports by Strange and Arthur, who served aboard the hospital ship USS *Repose* off the coast of Vietnam in 1966 (Chapter 4). Summaries of reports by Howard, Herman P Langner, and John A Renner Jr regarding excessive combat aggression follow. Perhaps of special note, Howard W Fisher, the division psychiatrist with the 1st Marine Division (March 1970–February 1971), made no specific mention of combat stress in his account of the avalanche of personality disorder referrals he saw later in the war (Chapter 2).¹²⁴

Excessive Combat Aggression and Atrocities

Reports Regarding Army Troops in Vietnam

This subject has been left for last because of its only tangential connection to military psychiatry (compared to military authority). In fact, although the war saw increasing concerns in the United States about excessive combat aggression in Vietnam, including atrocities (Figure 6-5), the psychiatric literature from the Army psychiatrists in the theater did not address this behavior. For example, midway through the war, 1st Infantry Division psychiatrist Bey (July–December, 1969) conducted a study of 43 soldiers referred because of violent behavior, but in none of the incidents studied were Vietnamese the targets.¹²⁵ One exception came from Jones (25th Infantry Division), who served in the first year of the war. He described a junior officer who was distraught because he had witnessed soldiers desecrating the body of an elderly Vietnamese civilian who was apparently killed when it was assumed that he was a Viet Cong sympathizer (the body was repeatedly dragged behind a jeep through the village) and felt powerless to intercede because he wasn't confident that his superiors would agree that this was wrong.²¹ The apparent absence of psychiatric attention to the subject could be accounted for by the paucity of publications by the psychiatrists assigned in Vietnam after 1968 to 1969 when, as suggested earlier, these incidents may have been more common. It is even more likely that such behaviors were not being brought to the attention of the deployed psychiatrists, at least as clinical matters, because command did not see them as pertaining to mental health. (In the WRAIR survey data, psychiatrist respondents estimated their involvement with excessive combat aggression as infrequent, and there was no significant difference in comparing respondents by

phase of the war in which they served [see Chapter 8, Table 8-4].)

Below are summaries of two hospital case records from the 935th Psychiatric Detachment that include such possible war crimes:

CASE 6-13: Psychomotor Regression Following Combat Losses and Responsibility for a Civilian Casualty

Identifying information: PFC Romeo was a 24-year-old, Mexican-born rifleman with 6 months in the Army and 2 1/2 months in Vietnam.

History of present illness: The patient was sent directly from the field to the 93rd Evacuation Hospital for “possible appendicitis and choking.”

Examination: Upon his arrival at the hospital, his abdominal complaints had abated, and he was observed to be lying in a fetal position, distracted, and repeatedly rhyming, “La-la-la.”

Past history: None recorded.

Clinical course: PFC Romeo was given an opportunity to get cleaned up, to ventilate, and then was put to sleep with Thorazine. In the morning he mobilized easily and was symptomatically much improved. He described several recent incidents in which platoon members had been killed, and he expressed anger that the ineptitude of his platoon leader was largely responsible. He also described an episode the previous evening in which he (and his platoon sergeant) went after a buddy who was wounded, heard something moving in the bushes, and shot into the bushes, only to find that he had killed a Vietnamese child who had previously befriended members of his platoon. He felt anguish about this. There was no evidence of psychosis.

Discharge diagnosis: Combat exhaustion, acute, moderately severe, manifested by somatic symptoms and regressive behavior. Stress: death of friends, anger at platoon leader. Predisposition: mild.

Disposition: Returned to duty following his overnight stay. He was referred to his division psychiatrist.



FIGURE 6-5. Human skull wearing a US Army captain's hat. This photograph was taken somewhere in Vietnam in 1970, during the drawdown phase, and serves as a reminder of the sometimes thin line between combat-appropriate aggression and excessive combat aggression. Whereas it was evidently someone's attempt at ghoulish humor, it suggests the creator's, and perhaps his reference group's, deeper feelings of moral tension regarding participation in America's (by then) discredited war. By placing an American hat on what is most likely an enemy skull, he has obliterated the distinction between the soldier and his dead enemy. This could express feelings of victory (and even revenge), or it could represent an effort at atonement, or both. Regardless, it would have been against military regulations and the law of war. Photograph courtesy of Richard D Cameron, Major General, US Army (Retired).

Source: Narrative Summary, 935th Psychiatric Detachment/93rd Evacuation Hospital.

CASE 6-14: Sergeant With Preexisting Emotional Instability

Identifying information: SGT Sierra is a 22-year-old white soldier with 5 years of Army service and 4 months service in Vietnam. He was assigned to the 11th Armored Cavalry Regiment.

History of present illness: He was admitted to the 93rd Evacuation Hospital following an incident in which he threatened the driver of his truck with his weapon and fired it in the air. Over the previous 2 months the patient was repeatedly abusive and angry, physically attacking others in his unit. In addition, he increased his alcohol intake. In a recent incident he became intoxicated and waded out into an unsafe river, requiring rescue by nearby ARVN rangers. He also bragged that he had a "fascination with pain," which, on one occasion, prompted him to grab strands of barbed wire to prove he was unfazed. On another

occasion he decapitated two enemy corpses and threatened to hang their skulls in the track in order to repulse members of his crew. The patient also complained of increasingly severe headaches that would produce double vision and blackout spells.

Past history: SGT Sierra was the sixth of seven children. Early development was reported as unremarkable, but his family members were adamant segregationists. He joined the Army following high school. He was arrested three times for drinking and disorderly conduct. Although distinguishing himself in his Army training (an honor graduate at NCO school and performing well in Drill Sergeant school), he also received four Articles 15 and was court-martialed for drinking, speeding, and destroying government property. He has had a stormy marriage with his wife of 2 years. She is German with an African American stepfather, and they have had numerous arguments over racial issues. He reported that his family treats him as the “black sheep” and rejects his wife because of her background.

Examination: The patient was noted to be anxious and smoking heavily. He had pressured and rambling speech, but he demonstrated relevant and coherent thinking. He acknowledged numerous obsessional rituals (counting), but these were not evident in the exam. There was no evidence of hallucinations or delusions. He repeatedly spoke of his fear that he had ruined his life, and that he was “going down hill.” He also expressed intense, prejudicial feelings about African Americans, which bordered on the bizarre.

Clinical course: He participated in group therapy, work therapy, and recreational therapy, as well as individual therapy. He was not a management problem although he tended to stay to himself and often complained of headaches. He was treated with a tapered regimen of Mellaril (begun at 200 mg/day) until the 6th day of his 7-day hospitalization.

Discharge diagnosis: Emotional instability. Stress: mild, exposure to normal military and combat conditions. Predisposition: severe; long history of immature behavior, inability to handle racial attitudes. Impairment: marked. Condition on discharge: unchanged; his condition existed prior to service.

Disposition: Returned to duty.

Source: Narrative Summary, 935th Psychiatric Detachment/93rd Evacuation Hospital.

The first case insinuates that it was accidental. The second suggests that a major contributor was the patient’s personality disorder. In neither case does the record indicate that there was command interest regarding excessive combat aggression. This does not mean there was none. It is puzzling that the list of precipitating stressors listed in the first case did not include the reported murder of the Vietnamese child, and that both clinical records seem to overlook questions regarding war crimes.

The following is a record of a forensic evaluation of a soldier referred to the 935th Psychiatric Detachment by his commanding officer in conjunction with several counts of assault on US personnel with a deadly weapon. (The requirements for conducting forensic psychiatric evaluations are in Appendix III—Format for Psychiatric Report of Sanity in Appendix 2, “USARV Regulation 40-34.”) It is likely that the Army’s psychiatrists in Vietnam were periodically required to provide forensic evaluations for a wide variety of misconduct, including violent behaviors and threats. In this case it is interesting that there was apparently no prosecutorial attention devoted to the alleged murder of the Vietnamese child.

CASE 6-15: Helicopter Door Gunner Facing Charges for Threatening Behavior While Drunk

Identifying information: E-4 Tango underwent a pretrial psychiatric evaluation conducted at the 935th Psychiatric Detachment. E-4 Tango is a 20-year-old E-4 with 28 months of active duty service and 19 months in Vietnam.

History pertaining to the charges: EM’s [enlisted man’s] service record, including in Vietnam, had been favorable, and he was allowed to extend in Vietnam in order to become a helicopter door gunner. Leading up to the events in question was: (1) the death of a friend and fellow door gunner, a loss for which the EM felt responsible because he had not flown on that mission (because of a recent hand injury resulting from fighting while drunk); (2) [a] few weeks later EM allegedly shot

an infant out of its mother's arms. [Author: whereas the report included no additional information regarding this incident, it suggested that it was assumed the child's death was accepted as collateral damage associated with combat activity.] As a consequence he felt intense guilt and was no longer willing to fire his weapon. ([T]he examining psychiatrist speculated that this incident coincided with displaced hostile feelings he had for the infant of another Vietnamese woman whom he believed he had impregnated); (3) [h]e was removed from flying and given a noncombat assignment; he was urged to curtail his drinking; and he was told he was being reassigned. The charges facing the EM arose after he got drunk, went to the flight line, and apparently threatened several individuals with a weapon, events for which the EM claimed complete amnesia [results of the criminal investigation were not available for this review].

Past history: EM had been "a rather headstrong boy who was somewhat spoiled" before the birth of his siblings. He reported that in his early development he demonstrated difficulty tolerating frustration and controlling hostile, sadistic impulses. Ultimately he managed to cope by rigidly controlling himself and becoming a loner.

Examination: Aside from presenting as somber, anxious, agitated, and tense, the mental status findings were unremarkable. Intelligence, social judgment, and conceptual ability were deemed within normal limits. Psychological testing was negative for psychosis.

Clinical course: Not applicable.

Final diagnosis: No psychiatric disease.

Disposition: EM was psychiatrically cleared for administrative or judicial proceedings. At the time of the examination he met Army retention standards and was deemed mentally responsible. Regarding the incidents in question, the evaluating psychiatrist indicated that the EM was "probably drunk," and that, although he had an earlier amnesic incident when he assaulted a friend while drunk, he was not subject to such episodes when sober. He concluded that the EM had been having increasing difficulty managing hostile, violent impulses, as well as guilt and remorse,

regarding his actions as a door gunner; and that alcohol served to [disinhibit him].

Source: Report of Psychiatric Evaluation, 935th Psychiatric Detachment/93rd Evacuation Hospital.

Reports From the US Marine Corps/Navy

Several of the Navy physicians who provided care for Marines in the theater published material bearing on the subject of excessive combat aggression in Vietnam. Howard served as a Marine battalion surgeon in 1968 and pursued psychiatric training shortly after returning to the United States. The combination of his close proximity to the troops and the fighting (he reported getting wounded) and his subsequent specialization training allowed him to have a unique vantage point for observation and interpretation regarding the connection between the challenges in adapting to combat stress at that time in Vietnam and the development of excessive combat aggression. According to Howard, the Marines of 1968 had to contend with fear and terror regarding the combat mixed with intense feelings of isolation from home and the familiar (causing feelings of "unreality," "adrift"); alienation from their surroundings (provoking "contempt toward Vietnam and its people"); and despair and hopelessness regarding the mission (stemming from their feeling the war was "futile and senseless"); and a "glaring absence of good leadership."

Furthermore, the real and frequent danger they faced not only fueled their combat motivation, but it also provoked their most primitive urges. ("Under the overwhelming threat of annihilation, our priorities regress to the survival state; all higher priorities, all ethical and moral considerations lose relevance, and only the survival of the individual and the immediate group retain significance."^{51(p133)}) Embedded in his reference to moral considerations Howard includes: (a) their anger at being sent far from home and isolated from "something real and human"—especially warm and desirable women (thus they reverted to the local prostitutes); and (b) that they relished the opportunity to satisfy a wish to kill (according to Howard, an almost universal desire but one that is generally repressed). Serving as a remedy, combat activity permitted them to "prove themselves," especially to their comrades, through the crudest myth of masculinity, "fighting and f--king," ("[thus] blurring the distinction between gun and phallus, to the extent that orgasmic release is

sometimes experienced in the very act of committing violence”^{51(p128)}). Howard also described some of the psychological and social defenses utilized by the Marines as they struggled to maintain their personal equilibrium: heavy reliance on slang and empty euphemisms to refer to the enemy and emotionally charged subjects (ie, kill, danger, fear, death); counterphobic, almost psychotic, denial of danger and a quasidelusional belief in one’s invulnerability; and intense (“pseudointimate”) love for one’s comrades. (These observations and reconstructions pertaining to troops in the field appear to validate the aforementioned impressions by Schwartz and by Nadelson derived from DAV veteran patients.)

Finally, Howard recommended some temperance of judgment of Marines regarding accusations of excessive combat aggression in Vietnam. “It is important not to distinguish too strongly between ‘normal’ combat killing on the one hand, and murder and atrocity on the other.”^{51(p133)} He also suggested that understanding these psychosocial dynamics can help to explain readjustment symptoms in some returnees whose suspension of civilian morals in Vietnam collapsed into guilt upon return to stateside life (the “real world”) and facing society’s repudiation of the troops who served there.⁵¹

Langner, a Navy psychiatrist who served aboard the hospital ship *USS Sanctuary* (1967–1968) at about the same time as Howard, published a report (“The Making of a Murderer”¹²⁶) that provided some corroboration of Howard’s observations. In Langner’s opinion, the My Lai massacre by Army troops was not unique because the problem of poorly controlled aggression, even toward fellow Marines, was endemic in Vietnam while he was there. According to Langner:

[M]any other such brutalities were reported to me by different individuals . . .

. . . Often a young man came in or was sent to me with the fear or threat of killing one of his superiors who he felt had harassed him or treated him unfairly. Others were sent to me after shooting holes through their “hootches” or throwing grenades around. On occasion such cases turned into incidents involving the indiscriminate killing of comrades. Fighting and “accidental” shootings among the men were frequent; they represented another way of discharging aggressions that were reaching unmanageable proportions. It should also be noted that many [of these] problems were dealt with through disciplinary rather than psychiatric

channels and therefore did not come to the psychiatrist’s attention.^{126(p951)}

Langner used a specimen case of a young Navy corpsman, “Bob,” to explore the concatenation of circumstance and personality that led Bob to murder a defenseless farmer, in front of an officer. Bob originally came to psychiatric attention after he apparently tried to take his own life in a morphine overdose. This was ostensibly brought about from survivor guilt following the death of a fellow corpsman in a firefight. However, when Langner conducted an amobarbital interview to facilitate Bob’s cathartic relief of what was assumed to be unrealistic guilt, Langner was surprised at the outpouring of guilt and sorrow associated with Bob’s participation in an earlier military action (“a bloody military operation . . . during which his unit had swept through a village, killing all living things, including men, women, children, and livestock. [Bob] described setting fields of rice ablaze ‘with my Zippo lighter’ and watched peasants shot down as they ran from their burning homes.”^{126(p950)}) Langner referred to these incident as “mayhem” and “a massacre.” He also noted that in the course of the narcosynthesis, Bob exhibited “fascination and pleasure.”^{126(p951)} These events preceded the death of the corpsman friend by several weeks and included the incident of his killing the farmer.

With respect to pre-Vietnam susceptibility, Bob, himself a son of a farmer, had always been mild-mannered and nonaggressive and wanted to become a corpsman to help others. However, according to Langner, Bob’s violent behavior flowed from repressed rebellious and destructive urges toward his passive but demanding father and his domineering mother, which led to lingering doubts about his masculinity and late-adolescent instability and instinctual recklessness (perhaps it was implied that Bob had used a reaction-formation defense against these urges in choosing to be a noncombatant corpsman). Once in Vietnam the breakthrough of these urges (ie, a “regression”) arose when Bob became increasingly insecure, frightened, frustrated, and angry as a consequence of the aggregate stressful circumstances he faced:

- enduring the hardships and misery associated with serving in an inhospitable and distant land;
- participating in an unpopular war;
- fighting against an elusive enemy that took its toll gradually and indirectly, thereby avoiding open

combat that would have allowed US troops to vent their anger and frustration;

- sacrificing for an indigenous people who were unwelcoming, ungrateful, suspicious, and often cooperated with the enemy;
- operating in a war-torn culture where death was common and the value of life had been cheapened;
- influenced by a group-sanctioned, killing mind-set that “swept away” the moral restraints of civilized society;
- enabled by a military authority that relinquished its traditional duty as “in loco parentis”; and
- encountering a specific releasing situation during which a mob mentality prevailed.

Similar to Howard’s theory, Langner surmised that Bob’s barbaric conduct gratified primitive destructive urges as well as sexual ones. (According to Grossman, a professor of military psychology, this is an underlying temptation within every soldier.³⁴) In the final analysis, however, Langner concluded that “Bob was in many ways an American Everyman.” By that he meant that, in explaining Bob’s brutality his preservice risk factors were far overshadowed by the “pathological circumstances” in Vietnam at that time. There is nothing in his report to indicate whether Langner notified military authorities about Bob’s confession or whether Bob was formally accused of war crimes.¹²⁶

Also from the vantage point of providing 3rd echelon care, Renner, also a Navy psychiatrist, offered his impressions regarding the epidemiology of psychiatric and related difficulties in Vietnam from his contact with over 1,200 Marine and Navy referrals. He served aboard the hospital ship *USS Repose* (1969) roughly a year after Howard and Langner and at the beginning of the American drawdown. Renner cataloged the numerous circumstantial features affecting the combat troops (then) that served to seriously erode social (military) structures, psychological defenses, mission identity, and associated military comportment, what he referred to as “hidden casualties” (drug abuse, disciplinary problems, and the numbers diagnosed as character and behavior disorder). These included the moral and ethical ambiguity consequent to the political upheaval in America; hostility toward the apparently ungrateful South Vietnamese; the individual rotation system, which accentuated preoccupation with each individual’s welfare and reduced ties to unit members to “superficial” ones based on “sharing a primitive

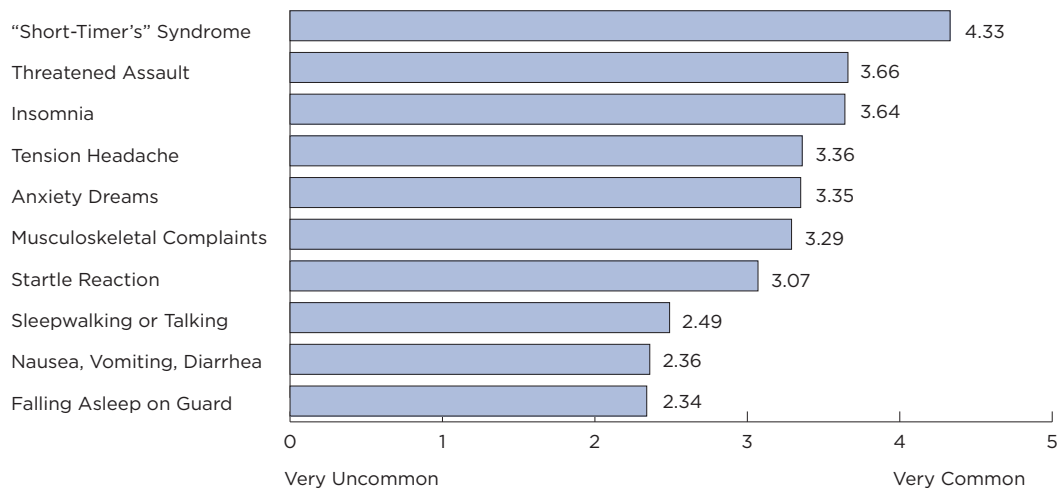
struggle for survival”; and the enemy’s “unacceptable” and “deliberate” terrorism, which ostensibly justified revenge, dehumanization of the enemy, and primitive aggression. According to Renner:

For the majority of soldiers these drives are not dominant, and the men are not personally aggressive. However, some men derive a vicarious and sometimes unconscious pleasure out of their involvement in the impersonal killing of war. . . . It reduces existence to its vital essentials, life or death. One can escape the boring details of civilized life and act out childhood fantasies of valor, power, and indestructibility. These fantasies are necessary to keep soldiers functioning under the terrible real dangers of combat.^{3(p174)}

In these remarks, Renner appears divided. Initially he was clear that these attitudes and behaviors were pathological, but then he reverted to arguing that they were necessary for adaptation. He also noted that for some, psychological conflicts arose when they sensed (in the theater or afterward) that their drives for survival, revenge, and aggression conflicted with their moral standards; and they became plagued with guilt for having participated in the violence (a “degrading and amoral struggle”).³ (Renner’s observations and reconstructions also appear to validate the aforementioned impressions of Schwartz and Nadelson.)

To conclude this section, from a historical standpoint it is fortunate to have available for study the reports by Howard, Langner, and Renner. Their clinical perspectives and impressions of the stressors affecting their patients and fellow Marines should not be dismissed because they are frankly disturbing, they seem too impressionistic, or they may be limited because of the prevailing medical, particularly the military medical and psychiatric, mind set and methodologies of the 1960s and early 1970s. In fact, they offer uniquely valuable insights because they were from a set of professionally trained observers of human nature who were actually working in the theater. Whereas their conclusions are sometimes ambivalent, they are mostly consistent with each other and give eyewitness testimony as to the deleterious effects of a mounting collection of bio\psycho\social-environmental stressors on combat-committed troops in Vietnam; the degrading effect the stressors had on overall military morale, order, and discipline; and the corrosive effects they had on

FIGURE 6-4. WRAIR survey psychiatrists' recollections of prevalence of specific symptoms or syndromes among combat-exposed troops above "uncommon"



Means of recollections of the prevalence of specific symptoms or syndromes among combat-exposed troops (presumes absence of a primary physical cause) along a 1-5 point scale with 1 = very uncommon to 5 = very common (N = 45). Values falling in the "uncommon" range are not included. They are hysterical amnesia (1.93), hysterical deafness and/or aphonia (1.78), narcolepsy (1.68), hysterical seizures (1.64), nocturnal enuresis (1.64), hysterical stuttering (1.61), and hysterical blurred vision (1.53).

the measured application of military aggression in the field, that is, within the constraints of the official rules of engagement—observations that were not limited to psychiatrically impaired individuals.

Reports of Veterans Regarding Excessive Combat Aggression

As the war lengthened, some corroboration of these observations came from psychiatrists and other mental health professionals who wrote about veterans they had evaluated, treated, or encountered who admitted responsibility for excessive combat aggression or acknowledged they witnessed it by others.^{68,127-132} Summarized below are the more data-centered reports that offer some illumination on the prevalence and causes of excessive combat aggression in Vietnam.

Joel Yager, an Army psychiatrist, reported on clinical evaluations of a subset of 31 Vietnam combat veterans who had a history of at least one self-confirmed kill in Vietnam (their service in Vietnam was 1966-1971 [most in 1968-1969], and they were evaluated 2 to 18 months after their return). These soldiers were still on active duty and were referred because of either symptoms or conduct problems. Participants were questioned about acts of violence against persons at

close range that were unnecessary from a military point of view, and almost half (14) reported they had engaged in such "personal violence." Another nine (30%) reported witnessing such behavior. All the personal violence participants had volunteered to go to Vietnam, and significantly more personal violence participants reported killing four or more persons in Vietnam than did nonparticipants. They also more frequently had a history of arrest prior to military service and could be distinguished from nonparticipants by the average number of items acknowledged in each of several groupings of negative pre-Vietnam variables.⁶⁸

Based on his clinical contacts with Vietnam returnees, William B Gault, an Army psychiatrist, seemed to corroborate the earlier observations in the field by Howard and Langner regarding the Marines and the intersection of the prevailing military culture with specific individual, circumstantial, and mechanical features to produce excessive violence against civilians. Gault specifically found the following factors as contributing to excessive violence in Vietnam: (a) adaptational paranoia ("The weary [soldier] realistically perceives threat from every quarter . . . he feels that the country itself may murder him at any moment"^{131(p451)}); (b) dehumanization of the Vietnamese ("the image of

TABLE 6-5. WRAIR survey psychiatrists' recollections of professional involvement with specific behavior problems among combat troops

Behavior problem	Overall mean	Combat (only) assignment mean	Hospital (only) assignment mean
Individual combat avoidance (malingering, self-inflicted wound, etc.)	2.83*	3.36	2.49
Excessive combat aggression (to civilians, prisoners, souvenirs of the dead)	1.76		
Group combat refusal	1.28		

Means of recollections along a 1-to-5 point scale with 1 = "very uncommon" to 5 = "very common" (N = 60-65).

*Statistically significant difference comparing 14 "combat" (only) psychiatrists with 36 "hospital" (only) psychiatrists ($p < .05$).

Modified from Camp NM, Carney CM. US Army psychiatry in Vietnam: Preliminary findings of a survey: II. Results and discussion. *Bull Menninger Clin.* 1987;51:19-37.

a degraded enemy is essential to the psychology of any robustly homicidal combat team"^{131(p451)}); (c) blurred responsibility ("the individual infantryman often has the sense that responsibility for the specific slaughter of a specific victim is not precisely his but that it is shared [both with higher ups and with combat buddies]"^{131(p452)}); (d) the need for action ("repudiation of passivity and the desire for vengeance"^{131(p452)}); (e) the situational preeminence of those with psychopathic tendencies; and (f) the ready availability of firepower ("Terrified and furious teenagers by the tens of thousands have only to twitch their index fingers, and what was a quiet village is suddenly a slaughterhouse"^{131(p453)}).

Similarly from the Marine Corps, Richard P Fox, a Navy psychiatrist, reported on a cross-sectional study of 106 Vietnam returnee clinical referrals (service in Vietnam was 1967-1969, and they were seen weeks to months after their return) that had severe reentry psychiatric symptoms and behavioral problems. Two-thirds showed evidence of difficulties handling their hostile and aggressive feelings in Vietnam; 16% reported continuing violent behavior in the United States; and 52% acknowledged being fearful of destructive outbursts. By their own account, while in Vietnam these Marines had exhibited a psychological deviation from the group-controlled and group-sanctioned "adaptive aggression," which is the norm for a member of a functioning combat team. They had regressed to a state of "hostile aggressiveness," a vengefulness that was motivated by a narcissistic rage. Fox posited that

the intense buddy relationships that typically develop between combat soldiers involves a range of narcissistic "mirror transferences" that, to varying degrees, leave each individual vulnerable to this regressive process should his "other self" be killed. Furthermore, in seeking to avenge this loss, he becomes devoid of concern for the victim and thus capable of atrocity. Most importantly, that act does not provide relief but instead leads to new anxieties related to fear of retaliation. According to Fox, although this has undoubtedly been a common battlefield process in past wars, the troops in Vietnam were more narcissistically vulnerable because of the political storm surrounding the war and the withdrawal of the public support for those sent to fight.¹³²

Obviously the reports by Yager, Fox, and Gault cannot be generalized to conduct in the theater because they are drawn from clinical populations who had returned to the United States. Late in the war, Bourne sought to explain the reported rise in combat atrocities by American soldiers in Vietnam through drawing on his multifaceted field research early in the war and his 1965 study of adolescent identity transformation occurring in Army basic training. He posited that excessive combat aggression represented the soldier's abandonment of his preservice values and beliefs as a result of the combination of: (a) the "militarization process" resulting from basic training—a training designed to force the new soldier to reject his civilian identity—an identity that had emphasized personal initiative—to be replaced with the obedient institutional identity of the military

TABLE 6-6. WRAIR survey psychiatrists' perceptions as to the etiological relevance of major risk factors in the pathogenesis of combat breakdown cases in Vietnam

Combat Environment Dimension	Mean N = 45	No. of Subjects Who Chose Item as Leading Factor (N = 43)
Noxious combat events specific to soldier: buddy killed, unit overrun, guilt about combat aggression or inactivity, helplessness under fire, new to combat	4.53	9
Combat magnitude: intensity, combined with duration, of individual's combat ordeal (general)	4.38	12
Combat intensity: the life-threatening circumstances faced by the individual (general)	4.02	2
total =		23
Personal Dimension		
Precombat personality traits: psychological susceptibility contributing to the soldier's adaptive failure or incapacitation under fire	3.94	12
Life circumstances: anxieties apart from combat events including regarding home, new baby, etc.	3.26	1
total =		13
Unit/Social Dimension		
Limited bonding: low acceptance by combat unit members due to limited intellect or social skills, atypical background, or newness to the unit	3.67	7
total =		7

Psychiatrists were queried on a 1-to-5 point scale with 1 = "not very relevant" to 5 = "very relevant" (N = 45).

organization; and (b) the brutalizing socialization to the war, especially the killing, which only occurred once he was in the theater.¹³³ (Several other Vietnam-era authors also complained about the dehumanization of American troops stemming from basic combat training, but they indicated they were voicing objections of the antiwar activists.¹³⁴⁻¹³⁶ However, later the same points were made articulately and dispassionately by Grossman.³⁴)

Notably, none of these physician/psychiatrists addressed the prospect that, overall, many American troops had developed a "habit of undisciplined violence"⁶⁶ that is seen among troops fighting an unconventional war against a guerrilla force that utilizes psychological warfare and the tactics of terrorism and violence against noncombatants (mentioned earlier); but perhaps it was implied. In a parallel fashion, it should be recalled that, as the war progressed there were increasing incidents of soldiers and Marines assassinating their military leaders, although such violence was apparently equally or more common in noncombat units.

Only Gary K Neller, an Army psychiatrist, and his colleagues addressed the insidiously corrosive psychological effects this type of warfare had on American combat troops. Their conclusions stemmed from their 1983 study of Special Forces veterans as well as from Neller's experiences as a Special Forces medic in Vietnam (1967). According to these authors: "Guerrilla warfare is essentially a political war, and its area of operation always exceeds the territorial limits of conventional warfare."^{63(p13)} Because of the guerrilla's smaller numbers and inferior equipment, it is self-defeating for him to hold territory. Thus the minds of individuals (in the case of Vietnam, the Vietnamese civilians and the allied troops) become the target, and psychological warfare is the means (ie, a series of actions—political, military, economic, and ideological—whose goal is to defeat the enemy by influencing their attitudes, opinions, emotions, or behavior). In general, there are four distinct phases seen among victims of guerrilla/terrorist violence: (1) initial denial, shock, and disbelief; (2) which becomes overwhelmed by reality—

producing frozen fright, clinging, and compulsive talking [*sic*]; (3) followed by depression and self-recrimination; (4) which in turn stirs attempts to prevent further victimization—the victim divests himself of his property and such sentiments such as feeling, caring, loving, and intimacy.

Neller et al posited that many of the soldiers and Marines serving in Vietnam were affected by a version of this process: “It is easy for the [soldier] to feel that his people at home, and his government, are indifferent to his fate. He embraces his feelings of rage and injustice; he then seeks reparation and revenge for his victimization to such an extreme that, often, he becomes psychologically disabled.”^{63(p28)} More specific to patients seen by military psychiatrists, the authors held that the guerrilla/terrorist warfare in Vietnam contributed to the initiation of combat stress symptoms, and for many, they became severe enough to become lifelong patterns.⁶³

WALTER REED ARMY INSTITUTE OF RESEARCH PSYCHIATRIST SURVEY FINDINGS: CHARACTERIZATION OF COMBAT STRESS REACTION CASUALTIES IN VIETNAM

The following is a summary of selective findings from the Walter Reed Army Institute of Research postwar survey (1982) of Army psychiatrists who served in Vietnam that bear on questions surrounding combat stress-generated psychiatric and related symptoms. In Chapter 5 it was reported that almost one-third (24) of the psychiatrist participants in the survey indicated that they saw combat reaction cases very infrequently in Vietnam. However, when the overall group of respondents (excluding the four USARV Psychiatric Consultants) were asked to apportion their clinical activities—treating cases or supervising their treatment by others—combat reaction cases accounted for 12.6% of their cases among the 10 diagnostic groupings, which ranked as the third most common group requiring clinical attention. Furthermore, the 14 psychiatrists who served *only* with combat units reported significantly higher estimates (21%) than the 36 who served *only* with hospitals/psychiatric specialty detachments (9.7%) [see Chapter 5, Table 5-3]. These data suggest that management of combat stress symptoms constituted more of a psychiatric challenge than previously recognized.

Prevalence of Specific Symptoms Associated With Combat Stress

Apart from formal diagnostic groupings, overall clinical challenges for the mental health professionals and paraprofessionals in Vietnam included a wide variety of psychological and physical symptoms or problematic behaviors. Regarding these, the 50 WRAIR survey participants who reported they saw combat reaction cases more often than very infrequently were asked to estimate the prevalence for 17 specific symptoms or syndromes among combat-exposed troops and to identify the medications they found useful in their treatment. Figure 6-4 presented means for the prevalence estimates for 10 items that exceeded “uncommon,” that is, a mean score above 2. The full set of responses is presented in Chapter 7, Table 7-6.

The 10 most common symptoms seen by the survey participants are consistent with the psychiatric literature from Vietnam and appear to corroborate the observation of Parrish, who indicated that the combat stress symptoms being seen in Vietnam in 1967–1968 were often milder than the more acute, disabling conditions seen in earlier wars. This suggests there was a substantial prevalence for psychological and psychophysiological disturbances that represented an insidious, low-grade, but only partially disabling stress on combat troops. Also noteworthy is the especially high prevalence of the short-timer’s syndrome, which, as discussed, evidently became more common in Vietnam as a consequence of the staggered, 1-year, individual troop replacement system.

Prevalence of Specific Behavior Problems Associated With Combat Stress

Survey participants were also asked to indicate the extent to which they became professionally involved in the evaluation and diagnosis of soldiers manifesting problematic behaviors in 17 categories. The full set of these responses will be presented in Chapter 8, Table 8-4; however, Table 6-5 presents the results for the three items that were specific for combat-exposed troops. Overall the means did not exceed the intermediate level (ie, above 3), and there were no statistically significant differences when comparing “early” war (30) and “late” war (35) survey participants for these items. The only mean that exceeded 3 was for individual combat avoidance, and that was a modest increase among the subset of 14 survey psychiatrists who only served with combat units. Evidently, these behavior problems were not

TABLE 6-7. WRAIR survey psychiatrists' perception of etiological relevance of group factors in the pathogenesis of combat breakdown cases in Vietnam

Circumstances Degrading Combat Group Morale, Bonding, and Commitment			
Counterinsurgency/guerrilla warfare*	3.84	Combat was brief, intermittent, intense, and fluid	2.96
Fragmentation of the unit by competing subgroups (re: race, drugs, or status)	3.42	Racial tensions and conflicts	2.93
Tactical errors by unit leaders led to loss of confidence	3.41	Soldiers generally antagonistic regarding combat objectives and risks	2.88
Retaking the same combat objectives perceived as "meaningless" missions	3.39	Minor unit losses cause exaggerated perception of impaired unit capability	2.81
Physically depleting combat: prolonged exposure to arduous field/combat conditions	3.39	Combat operations were in rugged, hot, tropical environment	2.79
Excessive rotation of officers (between field and staff after 6 months)	3.36	The unprecedented proportion of teenage soldiers	2.78
Combat leader perceived as incompetent or uncaring about welfare of his troops	3.30	Soldier alienation to the military and its values	2.78
Soldiers pessimistic about chances of strategic success (war's outcome)	3.26	Some soldiers disavowed national pride, felt United States was hopelessly divided	2.66
Individual rotation schedules in/out of Vietnam reduced unit bonding	3.23	US combat strategy of enemy attrition (body count vs territorial control)	2.63
Excessive combat losses to unit	3.21	1-year tours impaired soldier commitment to combat and unit objectives	2.54
Combat loss of a soldier-leader	3.08	Some soldiers disapprove of excessive aggression by unit members	2.26
Soldiers were pessimistic about chances of tactical success (local)	3.08	Concerns that weapons, equipment, and tactics were not suitable for Vietnam	2.20
Drug or alcohol use (general): unit health degraded by regular or excessive use	3.00	Some adopted a passive personal credo congruent with some civilian peers	2.00
Drug or alcohol use before or during combat by some soldiers	2.98	Doubt regarding medical care available under combat circumstances	1.49

Note: Means of perceptions concerning the etiological relevance of group factors in the pathogenesis of combat breakdown cases in Vietnam (N = 45). Survey psychiatrists were asked extent of relevance on a 5-point scale with 1 = "not very relevant" to 5 = "very relevant."

*Counterinsurgency/guerrilla warfare was defined in the survey questionnaire as, "Combat was rarely conducted in conventional set piece battles with clearly delineated lines of engagement in which allied forces fought with an identifiable enemy; but instead it consisted of fragmented combat with an enemy who blended in with civilians and took its toll with surprise attacks by his initiative with unconventional weapons and tactics."

pressing clinical challenges for the deployed psychiatrists. However, there is little reason to presume that the values in Table 6-5 necessarily reflected the real prevalence for these behavior problems. Command's involvement of psychiatrists would have been a predictably less common disposition compared to administrative or judicial ones.

Pathogenesis of Combat Breakdown in Vietnam

The 50 WRAIR survey psychiatrist participants who reported they saw combat reaction cases more

often than very infrequently were further queried as to the etiologic factors they perceived as contributing (ie, "relevant") in the development of combat reaction symptoms. For this purpose they were asked to indicate the extent of their agreement with a series of forced-choice questions divided into: (1) six *individual* stress factors that may have undermined the psychological resiliency of an individual soldier and (2) 28 *group* stress factors that may have degraded the morale and commitment of small combat units and consequently

undermined the psychological resiliency of soldiers. In these questions, combat reaction was further defined as “breakdown [of] combat effectiveness, whether in the form of psychiatric symptoms, or through the multitude or disabling behaviors noted in past wars to be the consequence of being psychologically and physically overwhelmed by the stress of battle.”

Individual Combat Stress Factors

Perhaps with the exception of the item with the lowest value (life circumstances), the means for the remaining five individual items in Table 6-6 are too close in value and thus can only be considered to be trends. However, a more strongly patterned response set arose when the survey respondents were asked to choose the leading item among the six individual combat stress items. The results strongly favored the combat environment dimension (total of 23); however, the 12 who chose “combat magnitude”—the item that combined intensity and duration—were equaled by the number who chose the personal dimension, “precombat personality traits”; and both exceeded those choosing the unit/social bonding. However, overall these results suggest that the survey group remained mostly divided on the etiologic question of individual predisposition versus combat stress.

Group Combat Stress Factors

As Table 6-7 indicates, the series of questions regarding group stressors on combat troops, which was drawn from the broader literature generated from the Vietnam experience, did not yield a clear pattern. Furthermore, more complex statistical approaches were avoided because of small sample sizes. On visual inspection it is noticeable that overall, the survey psychiatrists found group circumstances generally lower in pathogenic relevance than the individual influences. A partial explanation could lie in the fact that the psychiatric training of the times, including in the Army residency programs, favored individual-centered theories over group-centered, social ones for causation of psychiatric conditions. Also, limitations in practical military experience among the deployed Army psychiatrists meant that most were unfamiliar with the peculiarities of combat units and environments, especially the salience of group bonding and identity. Nonetheless, for reasons already discussed, it does seem notable that the leading item in the set was that of counterinsurgency/guerrilla warfare.

In conclusion, the items listed in Table 6-7 may have degraded the morale, combat motivation, unit cohesion, and fighting effectiveness of troops in Vietnam in various instances and to varying degrees; however, because of the paucity of information or study in the field, establishing links to psychological dysfunction or combat reaction must remain speculative. It is still hoped that this inquiry was a useful heuristic effort because psychiatrists are expected to serve as consultants to commanders about the full gamut of environmental and social factors that have the potential to degrade the troops who face the challenges of combat.

SUMMARY AND CONCLUSIONS

In the aftermath of World War II and the Korean War, American military psychiatry anticipated future high-intensity wars and broadened its focus to embrace a wide array of possible etiologic factors pertaining to soldiers disabled by overwhelming combat circumstances. Complex models were devised in which stress-inducing variables were offset by protective or controllable stress-mitigating ones (such as advancements in weapons and tactics, leadership, support in the field, preparation and training, and especially social bonding and esprit); and earlier etiologic propositions bearing on characteristics of individual soldiers, such as background variables and personality limitations, faded in importance. However, Vietnam was a different kind of war, a prolonged, counterinsurgency/guerrilla war, and it presented an opportunity, albeit regrettable, to assess these models and assumptions under new conditions; however, ultimately little attention was paid to the matter, evidently because of the low incidence of soldiers grossly disabled by combat stress (ie, with catastrophic, or shock, trauma).

In an attempt to characterize the stressors affecting the combat troops in Vietnam and their psychiatric and behavioral consequences, this chapter reviewed the available psychiatric and related documentation from the war, as well as selected responses from the WRAIR survey of veteran Army psychiatrists. Impressions derived from this review are summarized as follows:

- Whereas the fighting in Vietnam was often exceptionally bloody, soldier attrition from frank combat reactions (combat exhaustion) apparently

remained low throughout the war. After the first few years in Vietnam, Army medical and psychiatric leaders were relieved to note that psychiatric casualties from combat stress had remained exceptionally low, at least for the “classic,” or uncomplicated, combat reaction cases hospitalized at 3rd echelon facilities (averaging 6%–7% of psychiatric hospital admissions). The individual reports by some of the division psychiatrists also suggested generally low combat reaction incidence rates at 1st and 2nd echelons of care as well; however, from mid-1967 through mid-1969, rates apparently rose significantly in tandem with rising combat intensity (not to be confused with rising rates for other psychiatric problems later in the war). Chief among the proposed list of stress-reducing variables was America’s technological superiority. Overall, US troops were less exposed to sustained, psychologically exhausting fighting than in earlier wars, and contact with the enemy was typically intermittent and staged from relatively secure and easily supplied (via helicopter) bases. Some also credited the professionalism of the troops, the high caliber of their leaders, and the 1-year tour limits. The WRAIR series of biological and psychological field studies of combat stress and adaptation early in the war seemed to confirm that American troops were holding their own, even if they went to great lengths to deny and rationalize the hazards they faced.

- **Despite difficulties in measuring the incidence of combat exhaustion in the war, it was roughly estimated to be 25% of that seen in earlier, high-intensity wars.** The Army never released combat exhaustion incidence rates. In lieu of official figures, this chapter used a study of cases hospitalized at 3rd echelon facilities in 1966 and a study of psychotropic drug prescription patterns among outpatients by Army primary care physicians and psychiatrists in 1967 to estimate the combat exhaustion incidence rate over the course of the war as 5 to 6 cases per 1,000 troops per year for all three echelons of care (1965–1972). This would indicate that the risk of developing combat reaction in Vietnam was roughly 22% to 25% of that for the wars preceding Vietnam and supports the historical consensus that Vietnam was “low intensity” regarding its potential to generate acute

psychiatric casualties among combat-exposed troops. Nonetheless, three areas of uncertainty serve to cast doubt on this as a full measure of the psychiatric toll from combat stress in Vietnam:

1. **Diagnostic criteria for combat reaction cases in Vietnam were inconsistent.** Among the reporting Army psychiatrists, some strictly limited the diagnosis of combat exhaustion to soldiers who also evidenced exhaustion; some required presence of a psychotic state; some required substantiation of participation in intense combat; and some limited the diagnosis to soldiers who responded rapidly and fully to the forward treatment doctrine (typically augmented with pharmacotherapy). Combat-exposed soldier-patients who failed to satisfy these qualifications may have been categorized either as having a nonmedical condition (character and behavior disorder), labeled as an adjustment reaction, or diagnosed as other psychiatric conditions. The absence of standardized diagnostic criteria for combat reactions would also have produced inconsistencies among other Army physicians in the field, and they treated many more of these cases than did the psychiatrists.
2. **WRAIR psychiatrist survey findings suggest rates for combat stress disorders were higher than had been previously acknowledged.** Although almost one-third of psychiatrist respondents reported they had only rare exposure to combat-generated psychiatric casualties in Vietnam, the overall group indicated that 12.6% of their cases were combat reactions, and the 14 psychiatrists who served only with combat units reported combat reactions accounted for 21% of their cases. This alone suggests that it would be a mistake to minimize the psychiatric challenges in Vietnam associated with combat exposure.
3. **Psychotropic medications were prescribed liberally throughout the theater.** It was a common practice for psychiatrists as well as battalion surgeons and other physicians to prescribe anxiolytic and neuroleptic medications for troops as outpatients who had combat stress-related psychiatric symptoms and psychosomatic complaints. This will be

explored in Chapter 7, but it can be considered that, whereas these medications may have effectively reduced stress levels in combat troops, or served to suppress symptoms and therefore limited combat stress-related psychiatric disability, there were no systematic outcome studies conducted that would reveal whether the medication in question would have enhanced or degraded combat performance or led to adverse long-term effects.

- **Additional data suggest higher soldier dysfunction secondary to cumulative combat stress.** Other evidence suggests that combat-related circumstances in the theater were more broadly pathogenic than has been assumed, that is, that soldiers faced a more insidiously cumulative set of stressors, and that a wider spectrum of combat-centered psychiatric and behavior disorders resulted. Documentation includes not only that pertaining to the increased drug use among combat troops as the war progressed, which paralleled that for noncombat troops, but also anecdotal reports, data from the WRAIR survey of Army veteran psychiatrists, the Dattel and Johnson drug prescription study, and the findings by US Navy physicians regarding excessive combat aggression among Marines. In other words, evidently far more combat troops in Vietnam suffered with low-grade psychiatric, behavioral, and psychosomatic symptoms (partial trauma and strain trauma) in Vietnam compared to the relative few who became overwhelmed with combat exhaustion as in earlier wars. The higher prevalence of these more diffuse conditions and behaviors may have also corresponded with the war's depletion of soldier morale and fitness over its course.
- **Combat troops fighting in Vietnam sustained a unique collection of stressors.** Apart from the expectable challenges and privations associated with combat operations a long way from home and in a very foreign and unforgiving environment, it can be theorized that additional, overlapping stress-inducing features applied to combat troops in Vietnam that went mostly unrecognized by military leaders and the mental health personnel at the time:
 - **The requirement that conventional troops fight a counterinsurgency/guerrilla war.** The impact on conventional troops engaged in "psychological warfare" against determined counterinsurgent guerrillas apparently included a high potential for demoralization and associated psychiatric and behavioral disorders (in some instances resulting in excess combat aggression). Although the data presented from the WRAIR survey of veteran Army psychiatrists did not clearly isolate specific etiologic factors operating at the level of the group, it is noteworthy that the leading one was that of counterinsurgency warfare.
 - **Effects of the new, widespread use of the helicopter.** Although not applicable to all combat engagements, the frequency and dangers associated with heliborne assaults apparently greatly increased the stress levels for airmobile troops. Helicopter mobility also meant that units could be sustained in place during intense, prolonged combat with concomitant rise in stress levels.
 - **Compromised combat unit cohesion from the policy of individualized troop rotations, which was further aggravated by the USARV practice of rotating commanders out of the field after 6 months.** Soldier commitment (to military structure, leaders, and mission) and cohesion (within small units) have been found to be critical for mitigation of combat stress. These processes became greatly impaired in Vietnam by the personnel churning resulting from these two policies.
 - **Overall depletion of combat leaders and skills secondary to the 1-year tour limitations.** In planning for Vietnam, it was anticipated that the combat there would be less stress-inducing if combat tours were limited to 1 year. Because the war became protracted, the pool of experienced and professional soldiers, officers, and NCOs was gradually depleted; induction and promotion standards were relaxed; and replacements were less skilled, less confident, and less effectively led.
 - **Withdrawal of national approval for the war.** The repudiation of those sent to fight in Vietnam by those at home also severely demoralized service personnel, especially the ones doing the killing and bearing the greatest burdens. From a different vantage point, it was also especially challenging for citizen soldiers fighting in Vietnam—the growing and ultimately

preponderant numbers of drafted and draft-motivated volunteers whose growing resistance to serving in the theater was unprecedented. As a consequence, it can be reasonably speculated that, for many soldiers who served there, their moral tension was evidently raised to unbearable limits, with a consequent weakening of soldier confidence and combat effectiveness.

From this list of stress-inducing features it can be said that, whereas the overall combat ecology may have been less “exhausting” than earlier conflicts because of reduced demands for continuous combat operations, American ground troops fighting in Vietnam were nonetheless exposed to a more diffuse collection of stressors—variables not represented in the classic combat exhaustion model. It is especially notable that only the first two items on the list pertain to combat conditions in Vietnam: fighting a counterinsurgency/ guerrilla war, and the effect of the new heliborne maneuver capability; the others are stressors generated in the United States: political and military decisions regarding force selection/deployment, how the armed forces pursued their objectives in Southeast Asia, and the nation turning on its troops.

Finally, the data collected in this chapter do appear to verify the earlier impression that the incidence levels for the more extensive forms of combat stress-generated disability were much lower than were produced in the wars that preceded Vietnam. However, they suggest that, when all forms of combat stress-generated psychosocial disorders are considered, covert and overt, the psychological cost of fielding the Army in Vietnam was much greater than has been previously recognized. In other words, although combat exposure is often traumatic (ie, psychologically daunting, even overwhelming at the time), psychiatry’s experience in Vietnam, particularly with regard to cumulative stress, indicates that the profession is still shy of understanding the full set of variables that predict disability, whether in the theater or as a veteran. The data also suggest that the etiologic model of combat stress and disability must be broadened, to include extracombat variables (such as those pertaining to personnel selection and mobilization), and deepened, to recognize that there are certain limits as to how low the nation’s approval for the war can dip before fighting it becomes markedly more difficult from the standpoint of lowered morale, psychological

repercussions among combat troops, and consequent impediments to accomplishing military objectives.

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ATTACHMENT 6-1. COMBAT SPECIMEN #1: Viet Cong Ambush During the Battle of Dau Tieng

SLA Marshall, the noted combat historian, reconstructed the following combat action from Vietnam.

By the time Starr and Carter emerged into the open, the lead files in the column were two-thirds of the way across and stepping out briskly. That they had moved far better than they had scanned became apparent that instant.

In the lead was Pfc. Hawatha Hardison, a burly twenty-year-old Negro from Winston-Salem. He stopped dead in his tracks and stared, not believing what he saw.

Standing 10 feet away, directly in front of him, and unseen until that moment, were three uniformed figures, stock still and with their backs turned. They were togged in green pants and brown shirts, wore camouflaged pith helmets, and carried rifles at shoulder. So dressed, they had blended into the background.

Getting that sweet picture in one flash, Hardison's mind had room for one thought only: "We sneaked up on them and we've got them." In the nature of things, that would have been impossible. Yet Hardison and his mates had never heard that the Vietcong put out human lures, wittingly risking their lives to suck innocents into an ambush. It is a concept in any case too diabolical for ready acceptance by Western minds.

Before Hardison could manually react, the three figures darted away rightward toward the tree line at the rounded end of the clearing. It was a hot sprint. Still, Sgt. Ray Dickerson had time to shoulder his M-79 and fire three rounds while they were in sight. The explosions came just as they hit the trees and Dickerson thought he saw two of them stagger and fall. Maybe. Inevitably, the front half of the column, giving chase, became spread out broadside to the dense forest growth on the far side of the clearing, the precise effect for which the three stooges had risked their lives. The name of the game was Follow Me. Hardison had his own technical term for this random and spontaneous deployment: "We went at once into an overmatched formation."

Starr and Carter were six paces into the clearing when Dickerson fired. Neither said a word to the other. Busy with his own thoughts, Carter was not at once jolted into action by the M-79 rounds and later could not remember that he had heard them. Starr left him instantly and ran forward about 30 meters. Before he could flop down, automatic fire broke out from the far tree line directly against the platoon front. The hidden positions could not have been more than 20 to 25 meters from the uneven line of skirmishers. By now Carter was on radio to Bravo Battery: "We're in it, so stand by." The question was where to fire.

Where he lay, Hardison was being buzzed by bullets from his front, and he thought, from his left. It wasn't healthy. He decided to swing as far over as possible to the right, toward the point where the three VC had hit the tree line. He squirmed on his belly in that direction; and six or seven other riflemen followed him. It seemed, at first, like a fair hunch. Although that corner was not exactly quiet, to Hardison's anxious ear it sounded as if the bullet fire "was more thinned out there."

Private First Class Eugene Hicks, a twenty-year-old Negro from Forrest City, Arkansas, had been bringing along the M-60 machine gun in the second half of the column. A good soldier, on the quiet side, Hicks rushed the gun forward into the clearing on hearing the firing. It wasn't given to him to stay long, which was his good luck.

Sergeant Dickerson saw him and yelled, "Take that gun and get back to the trail opening! We're drawing fire from the rear."

Hicks might have let that go, but here came a reenforcing [*sic*] yell from Starr: "Get on the rear with that machine gun!" Hicks started to move. However, Dickerson, reacting compulsively to Starr's order, ran over and grabbed the M-60 from Hicks, then legged it for the trail mouth, with Hicks following along.

Dickerson flopped down as he came to the tree line and opened fire down trail. There were only 20 bullets in the M-60 (of which fact Dickerson was unaware) and within seconds the gun sputtered out. The sergeant wasn't given time to determine what had happened; a bullet hit him and he slumped over.

Hicks' ammo bearer had dropped his load 15 meters back along the trail. Being there on the spot, before Hicks could stop him, he picked up the gun and carried it back to the ammunition deposit. Hicks simply followed along. No one was present to give him orders, and besides, he was not the assertive type. Dickerson crawled along after them just to be near someone. No one was offering first aid and he wasn't asking for it.

The other machine gun was somewhere forward. Hicks didn't know just where; in his less than one-half minute on the open fire field he'd had little chance to see anything. What his ears told him was that the forward gun wasn't firing. He took that as a bad sign. Muffled by the forest, as if far off, he heard cries of "Medic, medic."

Seldom has a soldier had reason to feel lonelier than Hicks at this time. He did not know the platoon. He had joined it 30 days before. On his first morning, he had been hard wounded while on patrol. There followed 29 days in hospital. He had returned the prior evening, a stranger, and a stranger he stayed. It shouldn't happen to a dog.

ATTACHMENT 6-1. COMBAT SPECIMEN #1: Viet Cong Ambush During the Battle of Dau Tieng, continued

They now were drawing continuous fire from all around the clearing, in heavy volume and without a single break. Except for that growing rattle, the silence of surprise still hung heavily over the place. All the riflemen had gone flat, and for these minutes only, the depth of the elephant grass gave them a little hold on life. The enemy, too, showed signs of being plagued by nerves; most of the bullet fire was going high.

Hugging his radio in the center of the clearing, Carter heard Starr sing out above the rising whine of the metal, "Where's the goddamn artillery?"

"On the way, sir!" Carter yelled back.

And it was truly on the way; he had just called for it and had less than 30 seconds to wait for the first round.

Starr was on the PRC-25 (lightweight infantry field radio) again. This time he was begging higher command for mortar fire. Carter could hear him yelling, "You got to give me the 81s right now!"

But he was wasting time and breath. Back came the answer, "We can't help you. You're out of range."

Seconds later, he was pleading for gunships (rocket-armed helicopters). The anguish in his voice startled Carter. A minute before, artilleryman Carter had supposed that the infantry platoon would be getting the upper hand in short order. Now he sensed that the situation was becoming fully desperate, or at least he knew Starr thought so.

Starr was putting it over the radio to his company commander, Captain Crain:

"We must have help. There's more than a company against us. We're already hurting and we can't withdraw."

But Starr's estimate was pure guess, reckoned from the sound and fury of the enemy fire. So far, he personally had seen not one VC. Nor had Carter. It does not necessarily follow that there was no visible enemy movement. The grass still stood high and their heads were low; they had to be.

Carter asked himself, "What does it mean?" Continuous VC fire at almost measurable intervals would blaze higher from quadrant to quadrant, as if there were suddenly five or six automatic weapons working where one had been before. The movement was clockwise. Every half-minute or so the fusillade would swing to a different quarter. Carter thought he had it figured out: There must be fixed positions all around the clearing. The VC were clustering their weapons and swinging their killer groups from one fire bunker to another. Now if he could catch them during movement in the open—.

Carter had already made two adjustments. The first shells had landed far off. Now he had them coming where he felt they might check the rotary movement of the VC firers, provided he could lay the rounds on thick.

This was his message to the guns: "Give us continuous fire, not just a shell now and then."

A more pitiful request in the circumstances is beyond imagination. The 105-mm. battery had only three tubes firing in support. There was never any chance that artillery used in such weak numbers could influence the outcome, irrespective of how accurately the fire was adjusted.

And the last chance for adjustment died with Carter's words. In that split second, as the FO [forward observer] quit speaking, a bullet shot his radio's cord away. An earlier bullet had already shattered the microphone and Carter had put on a spare; at the same time another enemy slug snubbed the PRC-25 aerial one foot above his head. With that, Carter was dead as a communicator and could only witness the results. The friendly shells kept falling along the flanks of the clearing; there was no change in the volume of the enemy fire except that it steadily built upward. In these moments Carter lost his belief in the magic of artillery.

In these moments also Hardison was lying near one other member of the platoon whom he did not know. Between them was an ant hill about three feet high and looking as if it were made of concrete loosely poured into a weathered conical form. Both riflemen, firing, were using the base of the ant hill for protection, nothing in sight looking better.

There was an explosion, and quite suddenly, the ant hill was gone. Hardison was blown into a spin, and coming to rest, bruised but otherwise unhurt, said, "It looks like Charlie is using mortars, or was it a grenade?"

No answer was returned. His unknown friend, his body badly battered, was dead.

Hicks, low man on the totem pole, at the tail end of the formation, and well out of the fuss and fury, or so he thought, was under fire from both sides. Bullets were kicking up the dirt and clipping the leaves from the vines on his left and right. He guessed that there were two or three VC both ways from him, not more than 15 to 20 meters off, and he decided that their shooting was much too personal. Not wishing to make an issue of it, he got as close as possible to earth and said a few prayers.

Prayers were not for Hardison, he not being the praying type. He noticed that no yelling was rising from the American side, except for the cry, "Medic! Medic!" which rose close at hand, but he could hear it only faintly, almost as an echo at greater distance. His rifle jammed. Beating the M-16 on the ground, Hardison yelled, "Goddamn that weapon!" The impact, rather than the profanity, partly broke the block, but the rifle would no longer fire full automatic.

Another bullet smashed through the center of Carter's radio, and metal fragments from the instrument slashed him

ATTACHMENT 6-1. COMBAT SPECIMEN #1: Viet Cong Ambush During the Battle of Dau Tieng, continued

through the shoulder and left arm. Still, he felt no pain, and although he bled profusely, for the moment he did not notice it. He was too busy harkening to the voice of Starr and trying to catch a glimpse of him.

The infantry platoon leader was not more than 10 meters from Carter and directly to his left. He was scrabbling around in the buffalo grass, feeling for M-79 rounds, and finding a few of them. One of the thump gunners had died next to him from a bullet through the heart, and Starr had picked up the launcher. At top voice, he was calling out, "Squad leaders and machine gunners, hear me! Keep firing! But wait till you see targets. I'll tell you when to move."

It was a gallant effort and no less futile. The fight was then about 10 minutes along. Already the small plot where Starr and Carter were sprawled had been bracketed by mortar rounds. Carter reflected idly that there were no targets to be seen, and he wondered dully if anyone save himself was listening to Starr.

Then he heard Starr shout, "Bring the artillery closer!" Carter thought to himself, "Dear God, if I only could," and sensibly held back from singing out to Starr that he no longer had any control over the guns. "It's better that he not know," he thought to himself.

It was forbearance wasted. As he glanced toward the direction of the voice, he saw Starr rise to his knees with just the top of his head showing. In that split second, a bullet swarm hit him in the face and Carter knew from the motion as the body was lifted and thrown back that Starr was dead.

The artillery was not slowing down the VC attack one bit. The few who ultimately survived could all feel it was so. At his roost where the platoon had entered the clearing, Hicks could hear many enemy voices. But it was not the usual taunting chatter and laughter. It was steady and rhythmic: They were chanting directions to one another as they moved from bunker to bunker within the tree line. Hardison followed the beat, also. The VC were deploying more people around the clearing and the fire intensified in an ever-widening circle.

The ammo bearer, Private First Class Flagg, later killed, lay motionless within arm's length of Hicks. He became hysterical, and repeated over and over, "I know the sound. It's Chinese assault weapons." The litany jangled Hicks' nerves till, sickening of it, he snapped, "You shut your big mouth. Who doesn't know the sound?" The man quieted for only a few seconds.

Starr's RTO, Specialist 4 White, was already dead from a bullet burst. The forward machine-gun crew had been given no chance to open fire; as they went into position behind a fallen tree, about one rod ahead of Starr, that spot was fairly swarming with bullets.

One of the rifleman scouts, Private First Class Welch, tried to warn them. Having flattened, Welch rose on his haunches and yelled, "Get away from that spot. They're coming over. They're all around us!"

It was too late for them and for Welch. He was cut down by bullets before he could flatten and the same enemy machine gun, traversing, scythed the crew and wrecked the M-60.

Of that, very early in the game, had come the elimination of the platoon aid [*sic*] man, Specialist 4 Harrison. Cries arose from the forward ground, "Medic, medic! Doc, come help us!" There was never a more willing aide man and it was given to Hardison to see him die. Harrison rose from the grass a few feet from Hardison and started running toward the log, made not more than a few strides, and pitched over, dead from a bullet burst.

Carter's RTO, Private First Class Strong, was also down, although not yet unconscious. There were multiple wounds in his head, both shoulders, back, and both arms, some caused by bullets and others from the propelled fragments of the PRC-25. He lay there, eyes open but not speaking, and Carter also maintained silence.

From forward in the clearing, an unidentified rifleman came running toward Strong and Carter. His right sleeve streamed blood. "We're all that's left," he shouted. "Everybody's dead." Then he flopped down between the two of them. Neither said a word. They made no protest that the fight was still going; possibly they could not think on it. The unknown picked up the M-16 that Carter had dropped, relieved Strong of his Colt .45, and started firing them alternately. He did not bother to aim. Blood pulsing from his head, Strong turned slowly to stare at the newcomer as if not understanding. He was still saying nothing. This bizarre scene endured not more than two minutes. The stranger suddenly slumped over and died; his was not quite the last fire from the American side.

Carter, gradually dulling to all sensation from pain and loss of blood as his wounds took over, looked that way to see why the firing had stopped and noted for the first time, without shock or any reaction, that another wounded American was stretched out just beyond the diehard rifleman.

Flagg, the ammo bearer next to Hicks, had ceased muttering about Chinese assault weapons. A bullet had drilled him through the head. The fire seemed to slow a little. Hicks looked about for the first time. Two other U.S. dead lay face down within less than a body length to his left. He had no idea how and when they had been killed, nor could he sense how the fight was going in the clearing.

ATTACHMENT 6-1. COMBAT SPECIMEN #1: Viet Cong Ambush During the Battle of Dau Tieng, continued

Hardison, from his position in the center of the bulge at the extreme right of the clearing, knew more about that. He had wormed his way to another ant hill and intended to use it as a buffer till the finish, if given a chance. Five other rifleman still lived on that far flank, although none was firing. Hardison reckoned this was all that was left of the platoon. But he had no desire to go to them; he preferred the ant hill.

One of them, Private First Class Haskell, in his last moment of panic, arose shouting, "They're coming on!" and started on a dead run for the mouth of the trail. As he dashed past Hardison, he reached down, grabbed his M-16, and sped on. He almost made it to Hicks before he was cut down by a machine-gun burst.

It "scared the hell" out of Hardison, not so much the snatching for this last weapon as the wild expression on Haskell's face when he passed. One of the rifleman Haskell had quitted rose halfway as if to follow him. Before he could straighten, a bullet swarm hit him around the head and shoulders and toppled him. Hardison crawled over belly down, grabbed his rifle, an M-16, and wiggled back to the ant hill.

Snuggled behind it, Hardison checked the magazine. There were 10 bullets. Somehow he had lost his own extra magazines as the fight opened. Still seeing no human targets, he took deliberate aim, firing nine rounds toward the ground level of the tree line on the far side of the clearing.

Then he held his fire. Almost instantly, the clearing was silent, or at least free of lethal noises. Hardison heard men moaning and a few feeble cries of "Medic, medic." There was no one to respond; not one American on the field had been given first aid.

The loud silence did not exactly awe Hardison; a phlegmatic Negro, surly by nature, uncommunicative except with himself, he knew what it meant, and continued to hug ground. There no longer remained one American armed and in condition to fight.

He grunted, then checked to make sure that the last bullet was still there. It was. He had his moment of bitter satisfaction that he had hoarded it.

Hicks heard the roar and rattle cease in these same moments and wondered what was happening. Not more than 45 meters from Hardison, he was still unaware that the platoon had died, never really having been in the fight. Even a little distance may make a vast difference.

Carter knew that something had changed. The noise was gone. Physically, mentally, he was too weak to interpret what it meant. He was not resigned to death. He was not even thinking about it. To think at all had become an intolerable strain. He lay motionless.

During these minutes, General Rogers and his party in the Huey had at last made their fix. They were bucketing back and forth above the clearing and viewing it as if from an upper-gallery seat. Of the enemy, they saw nothing. They saw the forms of the Americans, sprawled in the grass, motionless, apparently lifeless. The Huey orbited over the curved end of the clearing, flying just above the trees. Rogers tried to count bodies. The Huey lifted again. Then Rogers could see "a few of the kids down below beckoning to me with their arms."

Over the radio, he heard the battalion commander (who was also somewhere aloft) say, "I've got Charley Company on the road in APCs coming fast to relieve the platoon." It stunned Rogers. Relieve the platoon? It was already too late. Via the road? Rogers knew that the bridge was out a mile or so short of the forest. He had seen it while circling. Someone had blundered.

Moments later, Hardison regretted that he hadn't kept all 10 bullets. Five enemy soldiers, uniformed in khaki and conical hats, entered upon the clearing at his end; the central figure was carrying a machine gun. It was Hardison's first sight of any enemy figure or weapon. As the five men advanced, the VC gunner dusted the foreground with his weapon, blasting in short bursts. They walked straight toward Hardison, on the way spraying bullets into the three riflemen who still lived, as well as the dead men.

Hardison kept wiggling around the ant hill, hoping (not praying) that by some fluke he would stay out of sight.

Fate was on his side, intervening in the strangest possible way. Suddenly, there was a smell of chemical in the air. Hardison got it faintly, and his eyes smarted. A slight wind carried it in Carter's direction, and he coughed heavily; it came to him that the enemy must be gassing the area to finish the fight, and that was still his impression days later. But Hardison had seen the thing happen. One of the dead riflemen near him had been carrying a gas grenade hitched to his belt. In blasting him, the gunner had put a hole through the container. The VC party turned and headed back toward the tree line to escape the drifting gas. Hardison lived on. All other Americans in the semicircular end of the clearing were now dead.

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ATTACHMENT 6-2. COMBAT SPECIMEN #2: Patrolling the Rong Sat Zone

The following description is provided by SLA Marshall, the noted military historian.

There was a common saying among the swamp rats who paddled and patrolled through the Rong Sat Zone night and day that anything seen moving there except the tide was bound to be Vietcong [VC] and a man had better shoot first and question later. . . .

All Americans who went into the Rong Sat [the great tidal bog south of Saigon] agreed that it was the worst possible place to fight a war, more fearsome than the jungle, gloomier than the rubber plantations, and made the Delta seem like a picnic ground by comparison. To patrol in the Rong Sat, soldiers either plodded through calf-deep slime, waded through the tide, or swam. There was no solid earth anywhere. The tree cover was mainly mangrove, with an occasional outcropping of banyan. The rare vegetated and green hummocks high enough to form an island at high water were dressed in grasses that cut the flesh. In a warfare conspicuous for its lack of uncomplicated terrain, operations in the Rong Sat Zone were bizarre beyond all other military experience.

. . . For man or beast, there is no relief from living strain in the Rong Sat. Eighty percent of its land mass is under water at high tide. The VC, who out of misfortune are detailed there . . . [endure] a debilitating, enervating existence beset by fever, fatigue, and fear.

Then why not leave them there alone to stew in their own juice? The explanation is elementary. Through the Rong Sat Zone twists and turns the main commercial channel of the Saigon River. Should that channel become blocked through enemy action, or should the shipping suffer constant harassment and heavy loss, the damage to Saigon and to the war effort could be enormous. Any such threat has to be parried methodically, however great the difficulty.

Operations by the [American] invaders have two familiar forms: the ambushing of sampans, usually by night, and prowling the swamp in search of enemy base camps, usually by day. Only by carrying out these movements regularly can the Vietcong be kept off balance and fighting defensively.

The Americans who go on patrol there do not stay longer than 72 hours. Such a stretch is enough to wear them down. Should they risk a longer tour in the swamp, the medical people figure, losses from jungle rot, foot infection, carelessness, fear, and drowning might become excessive. . . . After their 72-hour stint, the swamp rats are normally whisked to a nearby high-and-dry peninsula for a brief R & R. When deemed ready, they then go at it again.

Patrols in the Rong Sat go as light as possible. Each man perforce carries a poncho and a nylon hammock. The unit takes along a one hundred-foot nylon rope for stream crossings. Three air mattresses go with each squad. They are used to float nonswimmers across the deep-water passages; on an average, about one-third of the men in any American patrol are in that category. Four canteens of water are carried by each soldier; the only fresh water to be found in the Rong Sat are the stores in the VC base camps, brought in by sampan. . . .

When night coincides with high water, the game is that one squad or so of the patrol goes on ambush next to the deepest slough. Any VC base camp area is preferred for bivouac. The men not on ambush try to set their hammocks high enough to ride dry above the surging water. But [sometimes]...sleepers [are] warned only when their bottoms [are] wetted.

Although they [Charley Company, First Battalion, 18th Infantry, 1st Infantry Division] were a weapons platoon, they could not carry their mortars into the swamp. The weight was too much. So they had gone armed as a rifle unit. There was trouble enough with the M-16's and the ammo. Salt from the seawater built up around the metal and the rifle malfunctioned unless they were careful to keep rubbing the piece with vaseline. The ammo had to be lugged along in boxes or it would also corrode speedily. Such claymore mines as they toted were cased in waterproof bags.

To get across the mud flats at low tide, they would cut mats of foliage with their machetes, palm fronds being especially useful. Where the front runners stumbled through the ooze during the cutting, the last man in the column stayed dry-footed, walking along on a carpet. In this way, hacking as they went, they could move about three hundred meters in an hour. Three thousand meters of distance were rated as a long day's march.

Helicopters could not be used for resupply; there was not enough dry, flat ground anywhere to serve as a pad. So what they required for maintenance during the three days, they carried along.

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